

COMPREHENSIVELY COMBATING METHAMPHETAMINES: IMPACTS ON HEALTH AND THE ENVIRONMENT

JOINT HEARING BEFORE THE SUBCOMMITTEE ON HEALTH AND THE SUBCOMMITTEE ON ENVIRONMENT AND HAZARDOUS MATERIALS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED NINTH CONGRESS FIRST SESSION

OCTOBER 20, 2005

Serial No. 109-57

Printed for the use of the Committee on Energy and Commerce



Available via the World Wide Web: <http://www.access.gpo.gov/congress/house>

U.S. GOVERNMENT PRINTING OFFICE

24-258PDF

WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

JOE BARTON, Texas, *Chairman*

RALPH M. HALL, Texas	JOHN D. DINGELL, Michigan
MICHAEL BILIRAKIS, Florida	<i>Ranking Member</i>
<i>Vice Chairman</i>	HENRY A. WAXMAN, California
FRED UPTON, Michigan	EDWARD J. MARKEY, Massachusetts
CLIFF STEARNS, Florida	RICK BOUCHER, Virginia
PAUL E. GILLMOR, Ohio	EDOLPHUS TOWNS, New York
NATHAN DEAL, Georgia	FRANK PALLONE, Jr., New Jersey
ED WHITFIELD, Kentucky	SHERROD BROWN, Ohio
CHARLIE NORWOOD, Georgia	BART GORDON, Tennessee
BARBARA CUBIN, Wyoming	BOBBY L. RUSH, Illinois
JOHN SHIMKUS, Illinois	ANNA G. ESHOO, California
HEATHER WILSON, New Mexico	BART STUPAK, Michigan
JOHN B. SHADEGG, Arizona	ELIOT L. ENGEL, New York
CHARLES W. "CHIP" PICKERING,	ALBERT R. WYNN, Maryland
Mississippi, <i>Vice Chairman</i>	GENE GREEN, Texas
VITO FOSSELLA, New York	TED STRICKLAND, Ohio
ROY BLUNT, Missouri	DIANA DEGETTE, Colorado
STEVE BUYER, Indiana	LOIS CAPPS, California
GEORGE RADANOVICH, California	MIKE DOYLE, Pennsylvania
CHARLES F. BASS, New Hampshire	TOM ALLEN, Maine
JOSEPH R. PITTS, Pennsylvania	JIM DAVIS, Florida
MARY BONO, California	JAN SCHAKOWSKY, Illinois
GREG WALDEN, Oregon	HILDA L. SOLIS, California
LEE TERRY, Nebraska	CHARLES A. GONZALEZ, Texas
MIKE FERGUSON, New Jersey	JAY INSLEE, Washington
MIKE ROGERS, Michigan	TAMMY BALDWIN, Wisconsin
C.L. "BUTCH" OTTER, Idaho	MIKE ROSS, Arkansas
SUE MYRICK, North Carolina	
JOHN SULLIVAN, Oklahoma	
TIM MURPHY, Pennsylvania	
MICHAEL C. BURGESS, Texas	
MARSHA BLACKBURN, Tennessee	

BUD ALBRIGHT, *Staff Director*

DAVID CAVICKE, *Deputy Staff Director and General Counsel*

REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

NATHAN DEAL, Georgia, *Chairman*

RALPH M. HALL, Texas	SHERROD BROWN, Ohio
MICHAEL BILIRAKIS, Florida	<i>Ranking Member</i>
FRED UPTON, Michigan	HENRY A. WAXMAN, California
PAUL E. GILLMOR, Ohio	EDOLPHUS TOWNS, New York
CHARLIE NORWOOD, Georgia	FRANK PALLONE, Jr., New Jersey
BARBARA CUBIN, Wyoming	BART GORDON, Tennessee
JOHN SHIMKUS, Illinois	BOBBY L. RUSH, Illinois
JOHN B. SHADEGG, Arizona	ANNA G. ESHOO, California
CHARLES W. "CHIP" PICKERING,	GENE GREEN, Texas
Mississippi	TED STRICKLAND, Ohio
STEVE BUYER, Indiana	DIANA DEGETTE, Colorado
JOSEPH R. PITTS, Pennsylvania	LOIS CAPPS, California
MARY BONO, California	TOM ALLEN, Maine
MIKE FERGUSON, New Jersey	JIM DAVIS, Florida
MIKE ROGERS, Michigan	TAMMY BALDWIN, Wisconsin
SUE MYRICK, North Carolina	JOHN D. DINGELL, Michigan,
MICHAEL C. BURGESS, Texas	(Ex Officio)
JOE BARTON, Texas,	
(Ex Officio)	

SUBCOMMITTEE ON ENVIRONMENT AND HAZARDOUS MATERIALS

PAUL E. GILLMOR, Ohio, *Chairman*

RALPH M. HALL, Texas	HILDA L. SOLIS, California
NATHAN DEAL, Georgia	<i>Ranking Member</i>
HEATHER WILSON, New Mexico	FRANK PALLONE, Jr., New Jersey
JOHN B. SHADEGG, Arizona	BART STUPAK, Michigan
VITO FOSSELLA, New York	ALBERT R. WYNN, Maryland
CHARLES F. BASS, New Hampshire	LOIS CAPPS, California
JOSEPH R. PITTS, Pennsylvania	MIKE DOYLE, Pennsylvania
MARY BONO, California	TOM ALLEN, Maine
LEE TERRY, Nebraska	JAN SCHAKOWSKY, Illinois
MIKE ROGERS, Michigan	JAY INSLEE, Washington
C.L. "BUTCH" OTTER, Idaho	GENE GREEN, Texas
SUE MYRICK North Carolina	CHARLES A. GONZALEZ, Texas
JOHN SULLIVAN, Oklahoma	TAMMMY BALDWIN, Wisconsin
TIM MURPHY, Pennsylvania	JOHN D. DINGELL, Michigan,
JOE BARTON, Texas,	(Ex Officio)
(Ex Officio)	

CONTENTS

	Page
Testimony of:	
Coleman, Hon. Eric, Commissioner, Oakland County, Michigan, on Behalf of National Association of Counties	43
Colston, Stephanie, Senior Advisor to the Administrator, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services	14
Heerens, Joseph R., Senior Vice President, Government Affairs, Marsh Supermarkets, Inc., on Behalf of Food Marketing Institute	65
Kamatchus, Ted G., Marshall County Sheriff's Office, on Behalf of Na- tional Sheriffs' Association	60
Knapp, Gordon, President, PCH North America, Pfizer, Inc	55
Murtha, Peter, Director, Office of Criminal Enforcement, Forensics and Training, U.S. Environmental Protection Agency	30
Rannazzisi, Joseph T., Deputy Chief, Office of Enforcement Operations, U.S. Drug Enforcement Administration	24
Wagner, Mary Ann, Senior Vice President for Pharmacy, Policy, and Regulatory Affairs, National Association of Chain Drug Stores	51

COMPREHENSIVELY COMBATING METHAMPHETAMINES: IMPACTS ON HEALTH AND THE ENVIRONMENT

THURSDAY, OCTOBER 20, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH, JOINT WITH THE
SUBCOMMITTEE ON ENVIRONMENT AND
HAZARDOUS MATERIALS,
Washington, DC.

The subcommittees met, pursuant to notice, at 10:05 a.m., at 2123 Rayburn House Committee Building, Hon. Nathan Deal (chairman, Subcommittee on Health) presiding.

Members present, Subcommittee on Health: Representatives Deal, Shimkus, Walden, Bono, Ferguson, Burgess, Barton (ex officio), Brown, Gordon, and Dingell (ex officio).

Members present, Subcommittee on Environment and Hazardous Materials: Representatives Gillmor, Wilson, Otter, Sullivan, Murphy, Barton (ex officio), Solis, Pallone, Capps, Schakowsky, Inslee, Green, Baldwin, and Dingell (ex officio).

Staff present: Ryan Long, majority counsel; Jerry Couri, majority counsel; Tom Hassenboehler, majority counsel; Chad Grant, majority legislative clerk; Chelsea Brown, majority staff assistant; John Ford, minority counsel; Dick Frandsen, senior minority counsel; Jessica McNiece, minority research assistant and Alec Gerlach, minority staff assistant.

Mr. DEAL. The committee will come to order. I would first of all unanimous consent that Mr. Walden be allowed to enter an opening statement into the record. Without objection, so ordered.

Mr. WALDEN. Thank you, Mr. Chairman.

Mr. DEAL. I will recognize myself now for an opening statement and we will proceed with that portion of the hearing and then hopefully get to the witnesses as soon as possible.

I would like to, first of all, thank our witnesses for being here today. We recognize that you have expertise and we are grateful for your cooperation and attendance at this hearing. Our purpose of this particular hearing is to examine the impacts that the production and the use of methamphetamines have had on the health and the environment and how we can effectively and comprehensively attempt to win this battle against this devastating substance.

Methamphetamine poses an increasing threat all across the country. It is true in my home State of Georgia, particularly in the

northern and the central sections of our State. And law enforcement officials and health care professionals report that a more diverse group is abusing the drug. In parts of Northern Georgia that I represent, methamphetamine has emerged as the primary drug threat. And this drug has destroyed the lives of individuals, families, and communities throughout my district.

In April of this year, the Governor of the State of Georgia signed into law methamphetamine legislation which restricts the sale of products whose primary ingredient is pseudoephedrine to behind the counter of a retail or pharmacy store and requires that wholesalers of these products be licensed. Other States have taken actions similar to Georgia. And I look forward to discussing with the witnesses how effective these laws have been.

As Congress decides if Federal legislation action is the necessary next step, I believe it is important to attempt to craft policy that keeps products out of the hands of the people who would use them to cook up this addictive stimulant drug without—in the same time inhibiting the access of the overwhelming majority of people who simply want these medications to help fight colds and allergies.

We do have a problem that must be addressed. And the adverse health effects of regular methamphetamine uses is well documented and the long-term effects are evident: irreversible blood vessel damage, respiratory problems, irregular heartbeat, extreme anorexia, cardiovascular collapse, and death.

I would like to thank my good friend from Ohio, Mr. Gillmor, and his staff from the Environment and Hazardous Materials Subcommittee for joining us in preparing and conducting today's hearing. Mr. Gillmor is presently attending another meeting at this moment and will soon resume and will assume the Chair of the joint subcommittees, which are being convened for the purpose of this hearing. He will do that shortly.

Again, I thank all of the witnesses and I look forward to hearing from you as this hearing proceeds.

I now recognize my friend, Mr. Brown, from Ohio.

Mr. BROWN. Thank you, Mr. Chairman. And I am pleased to be part of this hearing with my friend from California, Ms. Solis, and both subcommittees, and my neighbor in Ohio, Mr. Gillmor.

Methamphetamine use is a perilous mistake for individuals, as we know, an onerous challenge for affected communities, a chronic drain on law enforcement and public health resources.

States like Ohio, where use of this drug was once rare, are witnessing an alarming rise in production and use and addiction. Since 2000, the number of labs seized in Ohio has more than quadrupled. Last year, authorities seized 104 meth labs in Summit County, Akron, Ohio, alone.

That is not because Summit County has a unique meth problem. As I will get to later, it is because Summit County has an aggressive meth eradication strategy. This drug is not like cocaine or heroin, with foreign cartels dumping dangerous poison into our neighborhoods.

In a hearing before the Government Reform Committee a couple months ago, Ohio officials testified that most of the meth producers feeding the drug line in—drug pipeline in Ohio were actually in the State cooking up the drug in “backyard” labs.

Instructions for cooking meth are available on the Internet, and the necessary ingredients are available at the local drug store. And taking even small amounts can result, as we know, in serious health effects, including hallucinations, psychotic violent behavior, hypothermia and convulsions. In the long-term, meth users suffer from significantly higher rates of Alzheimer's and stroke and epilepsy.

When authorities discover meth labs, they often find children in the homes exposed to the toxic ingredients and byproducts. And increasingly, the number of infants born addicted to meth, suffering from low birth weight and birth defects, is increasing.

The costs of meth control are real and a growing concern. In 2004 alone, the DEA and the State of Ohio spent \$680,000 cleaning up meth labs. It is easy to get. It is difficult to control. It is highly addictive. It is extremely harmful. It is not a public health crisis in the making. It is a public health crisis now.

In Summit County, as I mentioned, an innovative coalition of city—between civil officials working in cooperation with local law enforcement has invested the resources to clean up nearly 150 meth labs.

Their program is not only an excellent prototype for other Ohio communities, it sets a standard for the Nation as a whole.

Meth labs pose imminent environmental and public health dangers, so local officials have no choice but to act. It is our responsibility at the Federal level to ensure they don't have to act alone. We need a multi-pronged approach to this problem.

The primary ingredient used to make meth is available in many everyday cold medicines. A number of States require stores to take medicines, as the Chairman said, containing pseudoephedrine off the shelf and move them behind the pharmacy counter. Summit County, which I mentioned earlier has taken a leadership roll, has also taken this common-sense step to prevent meth production.

In addition to tackling the access issue, we need to—issue, we need to put resources into prevention and education. Americans are using meth to lose weight. Workers are using meth to stay up when they need to work late. We have to put resources into public awareness efforts to educate communities about the dangers of any kind of meth use for any kind of issue.

Today's hearing is an important step in our effort to reduce the devastating effects of the meth epidemic. I look forward to hearing from our witnesses. Thank you, Mr. Chairman.

Mr. DEAL. Thank you. Mr. Sullivan, do you have an opening statement?

Mr. SULLIVAN. No.

Mr. DEAL. All right. Ms. Solis, do you have an opening statement?

Ms. SOLIS. Yes, I do. Thank you.

Mr. DEAL. So recognized.

Ms. SOLIS. Thank you and good morning. I would like to thank Chairman Gillmor and Chairman Deal for holding this hearing on health and environmental impacts of methamphetamines. And I want also to thank all the witnesses that are here today.

The issue of methamphetamines and its array of impacts on our community is one that I am somewhat familiar with. Methamphet-

amine, or meth, is one of our Nation's most serious drug threats, and meth production is a significant problem throughout the State of California, where I reside. I believe it is the smaller and more numerous labs, often staffed by cookers who are themselves meth users, that are public safety threats because they are concealed in populated communities, some that we have found in my own district.

Small meth labs can be found in apartments, hotel rooms, abandoned facilities, and even cars. In my district, in the San Gabriel Valley of California, we have become plagued with small meth labs in hotels and homes. Over the past several years, nearly 200 meth labs were found and nine meth lab related explosions or fires resulted in injuries to police, firemen, and children.

The clandestine manufacture and distribution of methamphetamine has created a public health and safety crisis in Los Angeles County. Short-term exposures to high concentrations of chemical vapors that may exit into any functioning meth lab can cause severe health problems and even death. The chemicals and fumes that permeate the walls, the carpets, plaster, wood of meth labs, as well as the surrounding soil, are known to cause cancer, short-term and permanent brain damage, immune and respiratory system problems.

Meth not only harms those who use the drug but also harms anyone who comes in contact with the toxic waste in the meth lab, such as meth cookers, their families, and first responders. So often, children are the innocent victims of meth. More than 80 percent of all meth labs seized are found in homes, garages, apartments, motels, or mobile units where children are often present.

These labs, stocked with toxic chemicals and at high risk for explosion, expose children to highly dangerous living conditions. And these children may show permanent damage to their respiratory tracks. Meth labs are often discovered when firefighters respond to a lab fire. Police and firefighters have to take safety courses to handle meth situations because of the likelihood of explosions and invisible poisonous gases and other dangers.

The meth manufacturing process presents an extremely dangerous environmental hazard. One pound of meth produces six pounds of toxic waste. The waste is often dumped down in sinks, toilets, water wells, corroding pipes, septic systems, and sewers as well as contaminating our water supplies and groundwater. The waste can also be dumped into rivers and the ground near the lab along highways, in parks forests and on hiking trails.

Even months after meth labs have been closed, chemical residue still remains. These highly contaminated sites lead to costly clean-up and remediation. Environmental impacts include severe indoor contamination, toxic chemical dumps, hazardous waste disposal, and groundwater contamination.

A few former meth super labs have been—have become superfund sites, our Nation's most toxic sites. In the State of California, Region 9 EPA officials have had to engage in removal action at 15 meth sites. But there are no uniform Federal guidelines or standards for the cleanup and remediation of these meth labs. There has also been little research on the health effects associated with these

clandestine meth labs. Until the early 1990's, methamphetamine was made mostly in these labs.

While in the State Senate where I served, I addressed some of these issues by sponsoring legislation that would restrict the sale of two principal ingredients in making meth. My bill imposed new requirements on the sales of iodine and red phosphorous. I also requested funds for two high tech law enforcement vans quipped to fight and clean up meth labs in the Los Angeles County basin. And I worked very closely with our local law enforcement to do that.

The city of Covina in my district has also adopted a city ordinance limiting the sale of cold and allergy medications containing pseudoephedrine and ephedrine, such as Sudafed, Nyquil, and other nonprescription decongestants. California has the Drug Endangered Children Response Team, which specializes in seizing labs that manufacture methamphetamine and provides a coordinated response to the crisis that children—that we have found in the homes of these meth labs. More than 600 children, by the way, have been rescued from meth labs. All have received specialized medical and social services to diagnose and treat the physical and emotional effects of drug exposure.

Today, it is important to remember that meth is not only a California problem, but it is a problem for our country. All levels of government, as well as the private sector, need to work together to fight this growing problem. I look forward to hearing from our witnesses in coming up with some solutions to address this very important issue. Thank you. I yield back.

Mr. DEAL. I thank the gentlelady. Mr. Brown, your colleague has made me aware that today is your birthday and the Committee would join in wishing you a happy birthday. I have used my Chairman's privilege to deny him the opportunity to sing a solo. Mr. Murphy, do you have an opening statement? You are recognized.

Mr. MURPHY. Thank you, Mr. Chairman. I am pleased that we are holding this hearing today. We need to deal with the dual issue of the direct health impact of methamphetamines on individuals as well as the long-term toxic impact in our environment. And so it is fitting and proper that this Committee takes this on.

Certainly we are all concerned and should be highly concerned of the growing use of methamphetamines. And as small labs open up around the country whose sole purpose is to make money and develop more addicts out of our youth and adults, destroying their own lives, we also need to make sure that we are covering the long-term effects.

There are so many elements which are dumped and essentially creating these toxic sites, with substances—as red phosphorous, iodine, starter fluid, acetone, ammonia, drain cleaners, lithium. So many different things are a part of what is created in these meth labs, which then become a secondary health effect around them.

We have to recognize as one of the health effects of this is that some of the outcome also involves depression and other psychological disorders secondary to this. And as such, we have huge health problems that come out of this.

This is not victimless crimes that occur. And so often I hear people refer to drug crimes as victimless. But when we look at those who are caught up in the cycle of abuse of drugs, caught up in the

addictive net, and also then innocent bystanders effected by the toxic chemicals that are left behind, it is important that this Committee takes a strong stand and moves legislation to protect the health of the citizens of this country. I yield back.

Mr. DEAL. Thank the gentleman. I recognize the ranking member of the full committee, Mr. Dingell, for an opening statement.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and I thank you for holding this hearing. This is a very important matter and I am pleased that you are conducting these affairs.

Methamphetamine, or meth, and its effects are both serious and devastating. Methamphetamine-making operations have been uncovered in all 50 States. The total number of meth laboratory incidents in my home State of Michigan has increased dramatically.

Last year, 295 clandestine meth labs were discovered in Michigan, whereas 9 years ago only 10 labs were uncovered. Federal estimates indicate that more than 12 million Americans have tried meth and 1.5 million are regular users. Police officers nationwide rank meth as the No. 1 drug they battle today. In a survey of 500 law enforcement agencies in 45 States released in July of 2005 by the National Association of Counties, 58 percent said that meth is their biggest single drug problem compared with 19 percent for cocaine.

The ravages of meth use have affected our society perhaps more than any other drug in history. Meth addictions have dramatically increased the number of children placed in foster care, strained public health services as well as increased the number of violent crimes. Viable meth labs assembled in homes have resulted in explosions which maim and kill not only those cooking the drug, but also their families and other innocent persons. Users experience serious physical and mental health risks. Each pound of meth production produces five pounds of toxic waste.

Fighting the war on drugs has never been easy, nor are the solutions always straightforward. Many different proposals have been put forward with the intended goal of decreasing the amount of meth that is produced in the United States. Included in these proposals are recommendations to move certain over-the-counter drugs containing pseudoephedrine, which is the key ingredient in making meth, behind the counter. The expectation is that moving the pseudoephedrine-containing products behind the counter will allow for better monitoring of who is buying excessive or frequent amounts of these drugs.

Other proposals include recommendations to limit the number of pseudoephedrine-containing products that any one individual can purchase and recommendations to make pseudoephedrine-containing products available by prescription only.

Many States have already adopted a variety of measures aimed at curbing meth production and distribution. Congress should look over these programs, seek guidance from experts in the field, examine the efficacy of different State laws, and try to arrange, as best we can, the closest possible cooperation with State and local units of government and have a joint effort on these matters. We have to make informed decisions about how to best move forward with Federal legislation in this area.

I would like to note this morning that we have a distinguished citizen from Michigan prepared to present testimony on behalf of the National Association of Counties, the Honorable Eric Coleman, who is the Commissioner from Oakland County and First Vice President of the National Association of Counties.

I thank all of the witnesses for appearing before us today, Mr. Chairman. And I thank you for holding this very important meeting. And I yield back the balance of my time.

Mr. DEAL. I thank the gentleman. Dr. Burgess, do you have an opening statement?

Mr. BURGESS. Yes, Mr. Chairman, I do, but in the interest of time, I will submit that for the record and we can go on to the witnesses.

Mr. DEAL. All right. Ms. Wilson, do you have an opening statement?

Ms. WILSON. Yes, Mr. Chairman.

Mr. DEAL. You are recognized.

Ms. WILSON. Thank you, Mr. Chairman. I know a lot of us are well aware of the problems of methamphetamine in our communities. It was something that really started predominantly in the west and is now expanding across the country.

One of the problems with methamphetamine, of course, is its devastating effect and powerful addictive capacity and its propensity to cause those who use it toward violence against those they love and the children who depend upon them.

In addition, methamphetamine is pretty easy to make and gets compared to a lot of other drugs. And we have seen not only the explosion in meth labs across the country but the difficulty of cleaning up the toxic waste that is created in those meth labs. The cleanup from meth can range from \$1,500 to \$250,000. And that falls primarily on local communities who discover these laboratories in apartment buildings and garages and mobile homes across our communities. We need to continue to help local communities with those cleanup problems so they don't end up just in our sewer system.

Methamphetamine is now second to only marijuana as the most widely used illicit drug in the world and is particularly prevalent in the Western United States. The materials to make it are generally legally sold. And that is one of the reasons that I think we need to change some of our Federal laws to make it mandatory to put these drugs behind the counter and to reduce the amount—the level at which these drugs have to be controlled substances so that it is much harder for young people to walk into the local Walgreen's and get a couple of packs of Sudafed and be able to cook up meth.

It is destroying our families and our communities. And we see it in the spike in the number of children taken into foster care and the children found in the midst of the toxic waste of meth labs. And Mr. Chairman, I thank you for holding this hearing today.

Mr. DEAL. I thank the gentlelady. Mr. Pallone, do you have an opening statement?

Mr. PALLONE. Yes, I thank you, Mr. Chairman. As you know, meth abuse has spread throughout the country. And in response over the past decade, the Federal Government has ramped up its

regulation of ephedrine and pseudoephedrine, precursors that are often used in the illicit production of meth. Similarly, a number of States have enacted their own laws aimed at curtailing meth abuse. And many of these laws focus on the supply side of the problem and increase enforcement efforts aimed at the disruption of illegal drug markets. I am interested to hear from our witnesses on how effective these laws have been.

Research suggests that these efforts have had a limited impact on curtailing meth abuse, primarily because large scale meth producers have been able to access alternative supplies of meth inputs. Despite increased enforcement efforts over the past decade and the significant level of resources dedicated to reducing drug abuse, the problem of meth use continues to spread.

Mr. Chairman, I believe producers of illicit drugs must be held accountable to the fullest extent of the law and that we should do everything to limit the supply of meth. However, I think if we are truly going to tackle this problem we need to develop a comprehensive meth policy that not only reduces meth availability through precursor regulation but also reduces the demand for meth through prevention and treatment programs.

It is interesting that last night during special orders a number of the—on the Democratic side, particularly one from one of our western States, talked about how there have been some success in curtailing meth abuse through prevention and treatment as well as increased enforcement, but that at the same time, the Republican budget, the reconciliation bill that we are not dealing with today, are—actually have significant cuts in some of the programs that would—that have been successful against meth.

And I was looking at the Republican State budget and it actually has significant cuts in State grants for safe and drug-free schools, in the Federal anti-drug advertising, and also probably most important for meth, eliminating high density drug traffic area. The program for that is cut significantly.

And when we talk about these superlabs that produce large quantities of these drugs, the majority of these are located in Mexico. So when you are talking about eliminating a program that goes after high density trafficking, you know, that would go across State lines, you are directly going to impact enforcement of meth abuse. And so I think that this is another example where the Republican budget, which thankfully we didn't vote on today, would have a negative impact on the success that some of the States, as well as the Federal Government, are having in basically eliminating or cutting down on meth abuse.

I also would like to see what is said today about the problems—the environmental impact and the cleanup, as Ms. Solis said, because I think that is important as well—what we are doing in that regard. Thank you, Mr. Chairman.

Mr. DEAL. Mr. Otter, do you have an opening statement?

Mr. OTTER. Yes. Thank you, Mr. Chairman. I think, Mr. Chairman, in the interest of time, I think I will just submit it for the record.

Mr. DEAL. Very well. In any regard, does Chairman Barton of the Full Committee have an opening statement?

Chairman BARTON. That I do. Is it my turn?

Mr. DEAL. Yes. You would be recognized at this time.

Chairman BARTON. Thank you, Chairman Gillmor and Chairman Deal for holding this hearing. I think it is important that we address the health and environmental impacts of methamphetamine.

In the past decade, methamphetamine abuse has spread across the nation. It has become an especially severe problem for many rural areas and small towns. It used to be a city problem but now it has migrated to the country.

The drug is a highly addictive stimulant that can cause serious mental and physical health effects. Its primary ingredient is also the primary ingredient in many over-the-counter cold and allergy medications. We need to make it more difficult for criminals to gain access to these drugs, while at the same time not imposing unnecessary burdens that makes it more difficult for law-abiding families to obtain the medicines they need to treat their colds and allergies.

Methamphetamine currently comes from two primary sources. About two-thirds of the methamphetamines consumed in the United States come from illegal superlabs that organized crime groups have established in countries like Mexico. The second is from small toxic labs. In 2003, my home State of Texas reported 677 incidents associated with these small laboratories. These mini methamphetamine labs are everywhere: in basements, parks, and even in the trunks of cars. Even though these labs account for only a third of the meth, they also breed violent crime.

The cost of finding the labs and prosecuting the operators is burning a hole in countless county budgets. If that is not bad enough, the stuff used to produce this stuff is both explosive and poisonous. It poses a serious health risk and poses the risk of injury to police and firefighters who enter these labs. And it has become an environmental nightmare.

Often overlooked in the discussion of the proliferation of methamphetamine labs across the country is the contamination they leave behind. Local, State, and Federal enforcement officials have been struggling with researching and identifying the toxic byproducts. There are currently no uniform Federal standards or guidelines governing the process or the endpoint for cleaning up and remediating these small disaster areas. We look forward to hearing from the EPA and other agencies on what Federal authorities are currently using to list and identify these hazardous byproducts, what progress has been made, if any, in the remediation process.

We must take a comprehensive approach to addressing methamphetamine production. We can't focus just on the small labs and ignore the superlabs, because they account for twice the amount of the drug consumed. We need to make it more difficult to obtain the ingredients. We also need to take steps to choke off the superlabs, both through domestic efforts and international cooperation.

Methamphetamine is a dangerous drug. It hurts people. And I want to thank our witnesses for coming to testify, to provide their insight on how best to address the issue. I look forward to hearing from all of the witnesses and am particularly interested in their thoughts, if any, on the legislative proposals that have been introduced at the Federal level.

I want to thank my subcommittee chairman and the members of both of these subcommittees for attending this important hearing. With that, Mr. Chairman, I yield back my time.

Mr. DEAL. I thank the gentleman. Ms. Capps, do you have an opening statement?

Ms. CAPPS. Yes, I do.

Mr. DEAL. You are recognized.

Ms. CAPPS. I thank you for holding this hearing and am pleased that Congress is beginning to take action on what is a very serious problem. I am also proud of the work that our senator from California, Senator Feinstein, has done on behalf of our State.

We all relate to our local communities. And this morning's sublimines in my local paper are describing some of the latest research but also illustrating the problem. The numbers are given for the number of adults seeking treatment, which has doubled in my community over this—the—from between the last year and 2000. It is a growing problem in every location and across this country. And that is because as we have been describing. It is relatively cheap to acquire, easy to produce. By now everyone is aware that cold medications provide the basic elements needed to take—to make meth. And it can be taken in a variety of ways. It makes it way too convenient. And for this reason and others, meth amphetamine use is spreading across the country.

But while easier and cheaper than other drugs, its danger is no less. Over time, it—as we know, it leads to several health problems, including bone loss, liver, kidney, lung damage, and a variety of harmful psychotic behaviors often leading to violence.

I am especially concerned with the impact meth has on children. Children services are seeing increased numbers of abused or neglected children from families torn apart by methamphetamine use. In the same article I referred to, the numbers are given for the County of Santa Barbara and the 300 children in foster care. Over 52 percent of them were removed from their homes because one or more of their parents were using methamphetamine.

Children who live in homes where meth is produced can often suffer the same effects as users. Additionally, they are exposed to significant toxic waste that is harmful to their health and not easily cleaned up. And that has been noted already in this hearing as the opening statements. It may be there for years after that location stops being used as a meth lab. So families not even aware the home they are moving into had been contaminated in this way.

The problem cries out for a solution and we need to act. But as with so many challenges we face, we need to be balanced in our response. It is clear that we need to increase our assistance to law enforcement as they fight methamphetamine. We also need to take steps to make it harder for producers to acquire pseudoephedrine. But we also need to remember that the cold and allergy medications based on this chemical are needed by many Americans.

We need to balance efforts to secure them against law-abiding citizens who need to have easy access to them. So I look forward to hearing from our witnesses today about how this balance is best struck. And I yield back.

Mr. DEAL. I thank the gentlelady. Mr. Shimkus, do you have—

Mr. SHIMKUS. No, Chairman. I will waive.

Mr. DEAL. Mr. Ferguson, do you have an opening statement? Ms. Baldwin, do you have an opening statement?

Ms. BALDWIN. Yes, I do. Thank you, Mr. Chairman.

I join my colleagues who have spoken before me in emphasizing the hazardous consequences of methamphetamine on both individual health and the environment. And as we have heard, the use of meth and even just exposure to meth production can make a person's body and health deteriorate, just as meth production and its waste can be incredibly harmful to our environment.

This is clearly a major health and environmental threat. And I am glad that these subcommittees are taking up the issue. But Mr. Chairman, I am frustrated. And this frustration stems from actions taken beyond this Committee's jurisdiction, which have resulted in decreased funding for the Byrne-Grant Program.

I think the most powerful tool that we have available to combat meth is our capacity to prevent its initial manufacture. In able to do that, we will need strong law enforcement resources. And our law enforcement professionals in turn need reliable and steady programs to help fund their efforts.

I spent a good deal of time during the recent August recess meeting with law enforcement professionals in my district in South-central Wisconsin. Most of the district is rural. And as we know, the meth epidemic is particularly bad in rural areas. At every single one of those meetings, the local sheriff or the local police chief told me about their tremendous need for Edward Byrne Grant funding to combat the meth epidemic.

As my colleagues know, the Byrne Grant Program is designed to assist local law enforcement agencies in combating drugs and violence. And it is an incredibly important for local law enforcement authorities as they fight drug-related crime.

In Rock County, Wisconsin, the Byrne Grant allocations fund their drug unit. When this funding is cut, we are cutting the ability of local law enforcement to effectively carry out their efforts in the war on drugs. These law enforcement professionals told me time and time again that the problem is getting larger while the funding to fight meth and other illegal drugs is getting smaller.

Instead of increasing funding for the Byrne Grant Program, it has been on a steady decline. In June of this year, this House failed to pass an amendment that would have restored \$286,000,000 to the program. So while I am delighted that we are drawing attention to this very serious and widespread problem, I am also incredibly frustrated that we are not taking action to support the most powerful tool that we have available to prevent the manufacture of meth, a reliable and steady funding stream for local law enforcement.

Thank you, Mr. Chairman. I yield back.

Mr. DEAL. Ms. Schakowsky, do you have an opening statement?

Ms. SCHAKOWSKY. Yes.

I thank you, Mr. Chairman, the chairmen of both subcommittees, and ranking members. Much has been, I think, eloquently stated by many of my colleagues, and I will just submit my written testimony for the record.

Methamphetamine is perhaps the most destructive and hazardous drug we have ever had to confront because it is easy and

inexpensive to make, extremely potent, highly addictive, dangerous to manufacture, and dangerous to use.

Our Attorney General, like many of our local law enforcement officials around the country, is working very hard in Illinois to develop a comprehensive plan to address the serious problem of meth use in our State. Just a week ago today, she convened a meeting of local legislators and law enforcement officials from Illinois, Iowa, and Missouri.

She arranged for the summit after hearing reports from law enforcement authorities indicating that meth makers from Illinois' border States are coming to Illinois to purchase pseudoephedrine products, the key ingredient in making methamphetamines. Those States—many of those neighboring States—have laws that require virtually all over-the-counter products containing ephedrine or PSE to be placed behind pharmacy counters where legitimate customers may still obtain the drugs after showing State-issued identification and signing a log.

We have a law in Illinois that went into effect January 1 of this year. At the time that that was done in Illinois, it was one of the strongest in the country. But since then, several States have passed more restrictive laws. And therefore, the Attorney General is going to go back to the veto session of the Illinois State Legislature and ask for a law similar to that in Iowa so that we can keep up.

But I think what this says—the struggle of States and local authorities to deal with it—means that we need a comprehensive national strategy to deal with meth. We have a lot of people going from one State to another to find the best place where they can purchase the products that they seek. We want to reduce demand for this drug by educating Americans about its danger. We need to find and fund effective ways to prevent and treat meth addiction.

We also need to make sure there is a national plan in place to deal with the environmental impacts of methamphetamines. And we need more funding for enforcement, as was pointed out by Representative Baldwin, especially in high activity areas. I thank you, Mr. Chairman.

Mr. DEAL. Mr. Green, do you have an opening statement?

Mr. GREEN. Mr. Chairman, I would like to have—put an opening statement in the record and join my colleagues, but also show that my colleague from Illinois, Ms. Schakowsky, is a White Sox fan and hopefully this Astro hat, I will be able to give it to her next week.

But be that as it may, Mr. Chairman, I will put my full statement in the record. But getting away from baseball, I want to thank our panel for being here. We need to provide both the resources and the tools and—to let you do our job and to work with our local officials. Because my county officials in Houston talk about that methamphetamines is much worse than cocaine, heroin, and everything else that is on the street. So we need to do that and recognize it is a national issue, to make sure we empower our local communities and—with whatever Federal assistance we can do. So thank you, Mr. Chairman.

Mr. DEAL. At least it is a National League hat. Mr. Inslee?

Mr. INSLEE. Thank you. I want to speak of two powerful addictions. And the first is, of course, methamphetamine, which really

is the King Kong of drugs when it comes to addiction. And its addictive power is certainly stunning and terrifying every parent in the country. And it has touched every district in the country as well, of course.

And because—in light of that addiction that is really sweeping the country, it is really troubling to me and surprising that Congress has and is considering more cuts to the ability of the Federal Government and States and local police departments and schools to deal with this issue.

Ms. Baldwin spoke eloquently about these reductions in Byrne grants. I was just looking at a document called the Republican Study Committee Operation Offset document, September 21, 2005. And among the cuts that they have proposed or at least considering are an elimination of the State grants for safe and drug-free schools, a tool used to teach kids how devastating this drug is, elimination of Federal anti-drug advertising program, eliminate high density drug trafficking area. These cuts may be in the Republican budget. We are not sure. We haven't seen it yet.

And you have to ask yourself why, in the light of the powerful addictive capability of methamphetamine, the majority party would want to cut our ability to deal with these problems. And I think the answer is clear. Or at least the question should be asked is there a never equally powerful addiction to giving tax cuts to the wealthiest people in America. And does that addiction prevent us from continuing our efforts to deal with methamphetamines.

And I very much appreciate the Chairman's holding this hearing to hear about the first addiction. But if we allow the second addiction to hobble our abilities to deal with methamphetamines—and that bill was supposed to be up on the floor today. And we don't know what the reason for the delay was, but we do not want to see those Federal efforts hobbled because of the second addiction. And we will have that debate later. Thank you.

Mr. DEAL. I am pleased to welcome the members of the first panel here. And I will introduce you at this time. Oh, I am sorry. Ms. Bono, I did not see you. Do you have an opening statement you would like to submit?

Ms. BONO. I will submit it, Mr. Chair.

Mr. DEAL. All right. I would ask unanimous consent that all members would be allowed to submit their statements for the record. Without objection, so ordered. We are pleased to have three distinguished members of the first panel. And I am going to introduce you in somewhat reverse order from what we would normally go, but I have been told that we need to go in this order, so we will do that. First, Ms. Stephanie Colston, who is the Senior Advisor to the Administrator of Substance Abuse and Mental Health Services Administration of HHS, Mr. Joseph Rannazzisi, who is Deputy Chief of the Office of Enforcement Operations of the Drug Enforcement Administration, and Mr. Peter Murtha, who is the Director of the Office of Criminal Enforcement, Forensics and Training, of the Environmental Protection Agency. Lady and gentlemen, we are pleased to have all of you here today. And I will start with Ms. Colston. You are recognized for 5 minutes.

STATEMENTS OF STEPHANIE COLSTON, SENIOR ADVISOR TO THE ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOSEPH T. RANNAZZISI, DEPUTY CHIEF, OFFICE OF ENFORCEMENT OPERATIONS, U.S. DRUG ENFORCEMENT ADMINISTRATION; AND PETER MURTHA, DIRECTOR, OFFICE OF CRIMINAL ENFORCEMENT, FORENSICS AND TRAINING, U.S. ENVIRONMENTAL PROTECTION AGENCY

Ms. COLSTON. Thank you. Chairman Deal and Chairman Gillmor and members of both the Subcommittee on Health and the Subcommittee on Environment and Hazardous Materials, I am Stephanie Colston, Senior Advisor to Charles G. Curie. Charles G. Curie is the Administrator of SAMHSA, the Substance Abuse and Mental Health Services Administration, within the United States Department of Health and Human Services.

I am pleased to present SAMHSA's substance abuse prevention and treatment response to the methamphetamine crisis. Mr. Curie, unfortunately, had a longstanding commitment for today and sends his regrets that he is not able to testify this morning. I ask that my written testimony be entered into the record.

SAMHSA has a lead role to play in the demand reduction side of addressing drug abuse in the nation. SAMHSA is structured around our vision of a life in the community for everyone and our mission of building resilience and facilitating recovery. Our collaborative efforts with our Federal partners, States, local communities, faith-based organizations, consumers, families, and providers are central to achieving both our vision and our mission.

While the numbers of those who have used methamphetamine in their life, in the last year, or even in the last month have not grown over the past several years, what has changed is the level of their use. In 2002, 27.5 percent of those who said they used methamphetamine in the past month met the definition of being dependent. Two years later, in 2004, the percentage was 59.3 percent. The average person presenting themselves for substance abuse treatment today has been using methamphetamine for over 7 years.

Our first effort at SAMHSA is to try to prevent the use of methamphetamines. After consulting with prevention professionals and examining our own experience, SAMHSA believes that whether we speak about abstinence or rejecting methamphetamines, heroin, cocaine, alcohol, or preventing violence, or promoting mental health, we really are all working toward the same objective, reducing risk factors and promoting protective factors.

In the past 2 years, SAMHSA has awarded Strategic Prevention Framework grants to 26 States and territories to create a statewide prevention system and to advance community-based programs for substance abuse prevention. We expect to continue these grants and hope to fund seven new grants in fiscal year 2006, for a total of 93 million.

These grants are working with our five regional centers for the application of prevention technology that provide assistance to States and communities to systematically implement a risk and protective factor approach to prevention across the nation. The suc-

cess of the framework rests in large part on the tremendous work that comes from grassroots community anti-drug coalitions. That is why we are so pleased to be working with the White House Office of National Drug Control Policy to administer the Drug-Free Communities Program. This program supports approximately 775 community anti-drug coalitions across the country.

Unfortunately, there are many who are in need of treatment for methamphetamine abuse. In the past 10 years, the number of individuals entering treatment with primary drug of choice being methamphetamine has risen fivefold.

SAMHSA began working on the problems resulting from methamphetamine in 1998 by funding eight grants in California, Hawaii, and Montana to test treatment approaches for methamphetamine. I will talk more about this later in my testimony.

The primary way that SAMHSA supports treatment is through the Substance Abuse Prevention and Treatment Block Grant. Funded at nearly \$1.8 billion, these funds are distributed to the States using a formula dictated by statute. States have flexibility in the use of those funds, but they are typically used to maintain an existent system of care.

SAMHSA's Targeted Capacity Expansion Program focuses on reducing substance abuse treatment needs by supporting strategic responses to demands for substance abuse treatment services. Response to treatment capacity problems may include communities with serious emerging drug problems or communities struggling with an unmet need.

We are currently funding 20 methamphetamine grants in 11 different States, totaling nearly \$10,000,000. In his 2003 State of the Union Address, President Bush resolved to help people with a drug problem who sought treatment but could not find it. He proposed Access to Recovery, a new consumer-driven approach for obtaining treatment and sustaining recovery through a State run voucher program. State interest in Access to Recovery was overwhelming. 66 States, territories, and tribal organizations applied for the \$99,000,000 in competitive grants in 2004. We funded grants to 14 States and one tribal organization in August of 2004.

Of the States that are now implementing access to recovery, Tennessee and Wyoming have a particular focus on methamphetamine. Wyoming and Tennessee are just two examples of ATR's potential. ATR's use of vouchers coupled with State flexibility and executive discretion offer an unparalleled opportunity to create profound positive change in substance abuse treatment, financing, and service delivery across the nation.

To help better serve people with substance use disorders, a true partnership has emerged between SAMHSA and the National Institute of Health. Our common goal is to more rapidly deliver research based practices to the communities that provide services.

To specifically address the needs resulting from methamphetamine abuse, SAMHSA began working in 1999 to evaluate and expand on the Matrix model, which was developed in 1996 by the Matrix Institute with support from the National Institute on Drug Abuse. It is an outpatient treatment model that is responsive to the needs of stimulant abusing patients.

In 1999, SAMHSA Center for Substance Abuse Treatment funded eight grants in California, Hawaii, and Montana to compare the Matrix model to other cognitive behavioral therapies in the largest clinical trial network study to date on treatment for methamphetamine dependence. The result was the development and release of a scientific intensive outpatient curriculum for the treatment of methamphetamine addiction that maximizes recovery-based outcomes.

Information on the Matrix model and other cognitive behavioral approaches are available in a set of two DVD's produced by our Pacific Southwest Addiction Technology Transfer Center and from SAMHSA's Treatment Improvement Protocol #33, Treatment for Stimulant Use Disorders.

Education and dissemination of knowledge are key to combating methamphetamine use. SAMHSA's Addiction Technology Transfer Centers are providing training, workshops, and conferences to the field regarding methamphetamine. Additionally, SAMHSA has collaborated with ONDCP, the National Guard, NIDA, and the Community Anti-Drug Coalitions of America on a booklet, videotape, and PowerPoint presentation entitled "Meth: What's Cooking in Your Neighborhood?" This package of products provides useful information on what methamphetamine is, what it does, why it seems appealing, and what the dangers of its use are.

SAMHSA has been working in partnership with our colleagues at the Drug Enforcement Administration to provide funding to support a series of Governor summits on methamphetamine. These summits provide communities with opportunities for strategic planning and collaboration to combat methamphetamine problems faced in their own communities. And summits, to date, have been held in 15 States.

Chairman Deal, Chairman Gillmor, and members of the subcommittees, I appreciate the opportunity to testify here today and am available to answer any questions you may have.

[The prepared statement of Stephanie Colston follows:]



Testimony
Before the Subcommittee on Health and the
Subcommittee on the Environment and Hazardous
Materials
Committee on Energy and Commerce
United States House of Representatives

**Comprehensively Combating
Methamphetamines: Impacts on Health
and the Environment**

Statement of
Stephenie Colston
Senior Advisor to the Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services



For Release on Delivery
Expected at 10:00 a.m.
Thursday, October 20, 2005

Chairman Deal, Chairman Gillmor, and Members of both the Subcommittee on Health and the Subcommittee on Environment and Hazardous Materials, I am Stephenie Colston, Senior Advisor to Charles G. Curle, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). I am pleased to present SAMHSA's substance abuse prevention and treatment response to methamphetamine abuse. Many of our most pressing public health, public safety, and human services needs have a direct link to substance use disorders. This link is why the Administration places such a great importance on increasing the Nation's public health approach to prevention and to increasing the Nation's substance abuse treatment capacity.

SAMHSA is working to do just that. Our everyday work at SAMHSA is structured around our vision of "a life in the community for everyone" and our mission "to build resilience and facilitate recovery." Our collaborative efforts with our Federal partners, States and local communities, and faith-based organizations, consumers, families, and providers are central to achieving both our vision and mission. Together, we are working to ensure that the 23.5 million Americans with a serious substance abuse problem have the opportunity to live, work, learn, and enjoy healthy lifestyles in communities across the country.

Equipping communities with substance abuse treatment capacity is a clear priority for President Bush, HHS Secretary Leavitt, and Office of National Drug Control Policy (ONDCP) Director Walters. The Administration has embarked on a strategy that has two basic elements: discouraging drug use and reducing addiction; and disrupting the market for illegal drugs.

The strategy is backed by a \$12.4 billion Federal anti-drug budget proposed for FY 2006. SAMHSA has a lead role to play in the demand reduction side of the equation; naturally, we defer to our law enforcement partner agencies, such as the Drug Enforcement Administration (DEA), which is also testifying today, to address issues concerning the supply side of the equation. SAMHSA helps stop drug use through education and community action before it starts, and we heal America's drug users by getting treatment resources where they are needed.

I am pleased to report that our strategy is working. By focusing our attention, energy, and resources, we as a nation have made real progress. The most recent data from the 2004 Monitoring the Future Survey, funded by the National Institute on Drug Abuse (NIDA), confirms that we are steadily accomplishing the President's goal to reduce teen drug use by 25 percent in five years. The President set this goal with a two-year benchmark reduction of 10 percent. Last year we met and exceeded that goal. Now at the three-year mark, we have seen a 17 percent reduction, and there are now 600,000 fewer teens using drugs than there were in 2001.

Additionally, the most recent findings from SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH) clearly confirm that more American youth are getting the message that drugs are illegal, dangerous, and wrong. For example, 35 percent of youth surveyed in 2004 perceived that smoking marijuana once a month was a great risk, as opposed to 32.4 percent of youth in 2002. This is an indication that our partnerships and the work of prevention professionals, schools, parents, teachers, law enforcement, religious leaders, and local community anti-drug coalitions are paying off.

We know that when we push against the drug problem, it recedes, and fortunately, today we know more about what works in prevention, education, and treatment than ever before. We also know our work is far from over. In particular, we continue to be very concerned about abuse of prescription drugs and methamphetamine. The use of methamphetamine continues its assault as an extremely serious and growing problem.

THE SPREAD OF METHAMPHETAMINE USE

Methamphetamine use was initially identified in SAMHSA's Drug Abuse Warning Network (DAWN). DAWN is a public health surveillance system that monitors drug-related visits to hospital emergency departments and drug-related deaths that are investigated and reported by medical examiners and coroners across the country. In the early- to mid-1990's, DAWN data served as an early warning about the rise of methamphetamine use.

Almost immediately, this early alert from DAWN was confirmed through another SAMHSA data reporting and analysis system, the Treatment Episode Data Set (TEDS). TEDS provides information on the demographic and substance abuse characteristics of the 1.9 million annual admissions to facilities that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services. As early as 1992, TEDS data had indicated that methamphetamine treatment admissions were accounting for about 1 percent of all admissions. Within a decade, methamphetamine admissions grew at a rapid rate. Our most current 2003 TEDS data indicates treatment admission of persons with primary methamphetamine use problems increased from 21,000 in 1993 to 117,000 in 2003. Over half (55 percent) of these admissions were male. Of those admitted in 2003 for the treatment of methamphetamine use, almost three-quarters (73 percent) were white, followed by 16 percent who were Hispanic and 3 percent each who were Black and Asian/Pacific Islander.

With the recent release of SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH), a comparison study of data was completed which demonstrates the prevalence of methamphetamine use was unchanged in 2002, 2003, and 2004. In 2004, 1.4 million persons aged 12 or older had used methamphetamine in the past year and 600,000 had used it in the past month.

SAMHSA's 2004 NSDUH continues to demonstrate that a much younger population has grown vulnerable to methamphetamine's grip. The NSDUH now reports that young adults aged 18-25 had the highest rate of methamphetamine use among the 12 million Americans over the age of 12 who have used this illicit drug. Fortunately, the rates of past-year methamphetamine use among youths age 12-17 declined from 0.9 percent in 2002 to 0.7 percent in 2003, and has dropped again to 0.6 percent in 2004.

DAWN and TEDS data documented the proliferation of methamphetamine use over time, and a geographic pattern of methamphetamine use among the U.S. population emerged as well. Initially a problem in a few urban areas in the Southwest, methamphetamine use spread to several major Western cities and then east from the Pacific States into the Midwest, and now through the South and Southeast. For the United States as a whole, the methamphetamine/amphetamine admission rate increased by 420 percent between 1992 and 2002. Once thought of as a metropolitan drug problem, methamphetamine, or "meth," has now spread to rural America and is the fastest-growing drug threat in the Nation.

The alarming growth of methamphetamine use over the last ten years and, in part, its popularity can be explained by the drug's wide availability, ease of production, low cost, and its highly addictive nature. It is a popular drug because it is a synthetic drug that is easy to make. It is often produced in small, makeshift "laboratories," using equipment and ingredients that are – for the most part – readily available at local drug, hardware, and farm supply stores. The instructions for making methamphetamines are easily found on the Internet, and the equipment needed is as simple as coffee filters, mason jars, and plastic soda or water bottles. Making it even more inexpensive and easy to produce is the essential ingredient, ephedrine or pseudoephedrine. As you know, these substances are commonly found in over-the-counter allergy and cold medicines. Producing an entire batch of methamphetamine can take less than four hours from start to finish, making it more readily available than other illicit drugs.

Complicating the efforts to stop methamphetamine's growth is its highly addictive nature. Immediately, methamphetamine use produces a brief but intense "rush," followed by a long-lasting sense of euphoria that is caused by the release of high levels of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure. Eventually, methamphetamine leads to addiction by altering the brain and causing the user to seek out and use more methamphetamine in a compulsive manner. Chronic use leads to increased tolerance of the drug and damages the ability of the brain to produce and release dopamine. As a result, the user must take higher or more frequent doses in order to experience the pleasurable effects or even just to maintain feelings of normalcy.

Methamphetamine users and their families who are searching for treatment options, in addition to drug treatment programs, often rely on emergency rooms, the primary health care system, the mental health care system, child and family services, and the criminal justice system. As a result, addressing methamphetamine use often requires collaboration among law enforcement officers, prosecutors, judges, probation officers, treatment providers, prevention specialists, child welfare workers, legislators, business people, educators, retailers, and a number of other individuals, agencies, and organizations who all have critical roles in the prevention and treatment process.

SAMHSA'S ROLE IN PREVENTION

SAMHSA's earlier efforts in preventing methamphetamine abuse were channeled through its Center for Substance Abuse Prevention's (CSAP) Methamphetamine and Inhalant Prevention Initiative. This initiative funded grantees that were battling methamphetamine's spread to communities across the country. For example, in Oregon, health officials were reporting an increase in the number of youth who were seeking treatment for addiction to methamphetamine. In 2002, the "Oregon Partnership Methamphetamine Awareness Project" was awarded a SAMHSA grant that targets 9th and 10th grade students over a three-year period to prevent substance abuse among young people in school and community settings in rural Oregon. CSAP's Methamphetamine and Inhalant Prevention Initiative was designed to conduct targeted capacity expansion of methamphetamine and inhalant prevention programs and/or infrastructure development at both State and community levels.

To more effectively and efficiently align and focus our prevention resources, SAMHSA has launched the Strategic Prevention Framework. SAMHSA has awarded 26 Strategic Prevention Framework grants to States and territories to advance community-based programs for substance abuse prevention,

mental health promotion, and mental illness prevention. We expect to continue these grants and fund seven new grants in FY 2006 for a total of \$93 million in funding so far. These grants are working with our five regional Centers for the Application of Prevention Technology that provide technical assistance to States and communities to systematically implement a risk and protective factor approach to prevention across the Nation. Whether we speak about abstinence or rejecting drugs, tobacco, and alcohol; or whether we are promoting exercise and a healthy diet, preventing violence, or promoting mental health, we really are all working towards the same objective – reducing risk factors and promoting protective factors.

The success of the framework rests in large part on the tremendous work that comes from grass-roots community anti-drug coalitions. That is why we are so pleased to be working with the ONDCP to administer the Drug-Free Communities Program. This program supports approximately 775 community coalitions across the country. Consistent with the Strategic Prevention Framework and the Drug Free Communities grant programs, we are transitioning our drug-specific programs to a community-wide risk and protective factor assessment approach to prevention. This approach also provides States and communities with the flexibility to target their dollars in the areas of greatest need.

SAMHSA'S ROLE IN TREATMENT

While the number of individuals who have used methamphetamine in their lifetimes, in the past year, or in the past month has not grown in the past few years, the level of dependence on the drug has. In 2002, 27.5% of those who said they used meth in the past month met the definition of being dependent. In 2004 the percentage was 59.3%. You should also know that the average person presenting themselves for treatment today for methamphetamine addiction has been using methamphetamine for over 7 years. The level of dependence and the length of use present challenges to treatment providers, and yet we know that treatment works.

SAMHSA supports treatment primarily through the Substance Abuse Prevention and Treatment Block Grant. Appropriated at nearly \$1.8 billion in FY 2005, these funds are distributed to States using a formula dictated in statute. States have considerable flexibility in their use of the funds. States, if they want to, could use most if not all of the funds to address methamphetamine abuse. These funds, however, are used more often to maintain the current treatment system.

We also support treatment through competitive grants whereby public and non-profit private entities apply directly to SAMHSA for funds in areas chosen by the agency after consultation with stakeholders. Applications are reviewed and scored by experts from outside Federal government, and SAMHSA funds those applications with the best scores.

One such competitive program is our Targeted Capacity Expansion (TCE) program under which SAMHSA continues to help States identify and address new and emerging trends in substance abuse treatment needs. In FY 2004, SAMHSA awarded funds to programs in California, Texas, Oregon, and Washington to provide treatment for persons addicted to methamphetamine. Three other grants focused on methamphetamine were awarded to Hawaii and Iowa for a total of \$3.8million. In FY 2005, SAMHSA awarded an additional 12 grants in New Mexico, Georgia, Tennessee, Oregon, Texas, Montana, South Dakota, and California.

In his 2003 State of the Union Address, President Bush resolved to help people with a drug problem who sought treatment but could not find it. He proposed Access to Recovery (ATR), a new consumer-driven approach for obtaining treatment and sustaining recovery through a State-run voucher program. State interest in ATR was overwhelming. Sixty-six States, territories, and Tribal organizations applied and competed for \$99 million in grants in FY 2004. We funded grants to 14 States and one Tribal organization in August 2004. Because the need for treatment is great - as methamphetamine abuse rates alone have demonstrated - President Bush has proposed to increase funding for ATR to \$150 million in FY 2006.

Of the States that are now implementing ATR, Tennessee and Wyoming have a particular focus on methamphetamine. The State of Tennessee is using ATR-funded vouchers to expand treatment services and recovery support services in the Appalachians and other rural areas of Tennessee for individuals who abuse or are addicted primarily to methamphetamine. The Wyoming ATR program is also addressing the methamphetamine problem, focusing its efforts on Natrona County. This county has the second-highest treatment need in the State and is considered to be at the center of the current methamphetamine epidemic in Wyoming.

Wyoming and Tennessee are just two examples of ATR's potential. ATR's use of vouchers, coupled with State flexibility and executive discretion, offer an unparalleled opportunity to create profound positive change in substance abuse treatment financing and service delivery across the Nation. And, although it is reassuring to focus on treatment initiatives and the progress being made, we can and must do more to prevent drug use before it begins.

Including the TCE and ATR competitive grant programs, the total amount of competitive grant funding specifically for methamphetamine in FY 2005 is \$16,756,642.

SCIENCE TO SERVICE

To help better serve people with substance use disorders, a true partnership has emerged between SAMHSA and the National Institutes of Health (NIH). Our common goal is to more rapidly deliver research-based practices to the communities that provide services. SAMHSA is partnering with the pertinent NIH research Institutes - NIDA, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health - to advance a "Science to Service" cycle. Working both independently and collaboratively, we are committed to establishing pathways to rapidly move research findings into community-based practice and to reducing the gap between the initial development and widespread implementation of new and effective treatments and services.

As an example, SAMHSA began working on the problems resulting from methamphetamine in 1998 with a competitive grant program designed to expand on work done at NIDA on effective treatment for stimulants. SAMHSA's Center for Substance Abuse Treatment (CSAT) Methamphetamine Treatment Project (MTP) was the largest randomized clinical trial of treatments for methamphetamine dependence to date. Eight grants were funded in California, Hawaii, and Montana. This effort helped identify proven ways of treating those dependent on methamphetamine.

The clinical trials were used to evaluate and expand on the Matrix Model, which was developed in 1986 by the Matrix Institute with support from NIDA as an outpatient treatment model that was

responsive to the needs of stimulant-abusing patients. CSAT compared the Matrix Model to other cognitive behavioral therapies. The result was the development and release of a scientific intensive outpatient curriculum for the treatment of methamphetamine addiction that maximizes recovery-based outcomes. It is through this evaluation and our experience with behavioral cognitive therapies that we know that treatment works. Information on the Matrix model and other cognitive behavioral approaches are available in a set of two DVD's produced by our Pacific Southwest Addiction Technology Transfer Center and our Treatment Improvement Protocol (TIP) #33 - Treatment for Stimulant Use Disorders. These are available through the National Clearinghouse for Alcohol and Drug Information (<http://www.ncadi.samhsa.gov>).

Treatment Improvement Protocols are best practice guidelines for the treatment of substance use disorders and are part of the SAMHSA's effort in conjunction with the National Institute of Health to bring science to service. TIPs draw on the experience and knowledge of clinicians, researchers, and administrative experts. They are distributed to a growing number of facilities and individuals across the country. TIP #33 describes basic knowledge about the nature and treatment of stimulant use disorders. More specifically, it reviews what is currently known about treating the medical, psychiatric, and substance abuse/dependence problems associated with the use of methamphetamine and cocaine. SAMHSA has also published a Quick Guide for Clinicians as well as Knowledge Application Program (KAP) Keys that are also based on TIP #33.

Education and dissemination of knowledge are key to combating methamphetamine use. SAMHSA's Addiction Technology Transfer Centers (ATTCs) are providing training, workshops, and conferences to the field regarding methamphetamine. The Pacific Southwest ATTC has developed two digital Training Modules on Methamphetamine. Additionally, SAMHSA has collaborated with ONDCP, the National Guard Bureau's Counter Drug Office, NIDA, and the Community Anti-Drug Coalitions of America (CADCA) on a booklet, video tape, and PowerPoint presentation entitled, "Meth: What's Cooking in Your Neighborhood?" This package of products provides useful information on what methamphetamine is, what it does, why it seems appealing, and what the dangers of its use are.

Additionally, SAMHSA has been working in partnership with the DEA to provide funding to support a series of Governors' Summits on Methamphetamine. These summits provide communities with opportunities for strategic planning and collaboration building to combat methamphetamine problems faced in their own communities. Summits have been held in 15 States.

In conclusion, if we continue to foster these initiatives and further our goals of expanding substance abuse treatment capacity and recovery support services and of implementing the strategic prevention framework, we will simultaneously better serve people in the criminal and juvenile justice systems, those with or at risk of HIV/AIDS and hepatitis, our homeless, our older adults, and our children and families. We are doing our part at SAMHSA. We have been building systemic change so that no matter what drug trend emerges in the future, States and communities will be equipped to address it immediately and effectively before it reaches a crisis level.

Chairman Deal, Chairman Gillmor, and Members of the Subcommittees, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

Mr. DEAL. Thank you. Mr. Rannazzisi?

STATEMENT OF JOSEPH T. RANNAZZISI

Mr. RANNAZZISI. Good morning, Chairman Deal, Representatives Brown and Solis, and distinguished members of the House Committee on Energy and Commerce, Subcommittee on Health, and Subcommittee on the Environment and Hazardous Materials, on behalf of Drug Enforcement Administration Administrator Karen B. Tandy, I appreciate your invitation to testify today regarding the DEA's efforts to combat methamphetamine trafficking and its abuse across the United States.

Methamphetamine's devastating consequences are felt across the country by innocent children, adults, government agencies, businesses, and communities of all sizes. The DEA is well aware that combating this drug requires a multi-faceted comprehensive approach. In addition to enforcement efforts, the DEA is combating methamphetamine by providing training to our State and local partners, administering the cleanup of labs, providing assistance to the victims of methamphetamine, and educating communities to the drug's dangers.

The methamphetamine consumed in the United States originates from two general sources. It is estimated that approximately two-thirds of the methamphetamine consumed in this country comes from Mexico and California-based Mexican drug trafficking organizations that control superlabs with approximately one-third coming from the small toxic labs. Although these small toxic labs produce a relatively small amount of methamphetamine, they have spread across much of the country and present unique challenges for law enforcement.

Successes of the domestic front against superlabs have increasingly resulted in the movement of these labs to Mexico. In an effort to combat methamphetamine and its precursor chemicals before they reach the U.S., the DEA has forged agreements without international partners to prescreen shipments of pseudoephedrine in an attempt to ensure that it is used for legitimate purposes. These international efforts have resulted in significant seizures of precursor chemicals capable of producing tons of methamphetamine.

Domestically, small toxic labs continue to overwhelm many law enforcement agencies, especially those in rural areas. In an effort to combat these labs, many States have either enacted or have legislation pending, which places restrictions on the sale of pseudoephedrine. The Administration is aware of the various approaches enacted by States and supports the development of Federal legislation to fight methamphetamine production, trafficking, and abuse, denying methamphetamine cooks the availability to gather the ingredients they need while balancing the need for law-abiding citizens to be able to access commonly used cold products in an approach that works.

Law enforcement officers involved in these hazardous investigations require specialized training. And since 1998, DEA has offered a robust training program for our State and local law enforcement partners, providing basic and advanced clandestine laboratory site safety training. Since inception, the DEA has trained over 9,300 State and local officers and 1,900 DEA employees. Each course is

provided at no cost to qualified State and local law enforcement officers, as is the equipment needed to safely investigate and work in these hazardous conditions.

As was said before, the manufacture of a pound of methamphetamine results in about five to six pounds of toxic waste, which is often disposed of by lab operators by pouring it on the ground, down drains, or into sewers and streams, polluting our environment.

While we can do little once the waste is released, in 1990, the DEA established a hazardous waste cleanup program to address environmental concerns from the seizure of clandestine drug labs. This program promotes the safety of the law enforcement personnel and the public by using qualified companies with specialized training and experience to remove hazardous waste.

Through this program, the DEA administers the cleanup of the majority of the labs seized in this country. In fiscal year 2004, the cost of administering these cleanups was approximately \$17.8 million.

More than any other controlled substance, methamphetamine trafficking endangers children through exposure to drug abuse, neglect, physical and sexual abuse, toxic chemicals, hazardous waste, fire, and explosions. Each of the DEA field divisions has a victim/witness coordinator to ensure that all endangered children are identified and that the child's immediate safety is addressed by child welfare and health care service providers.

There are no easy answers to combating the spread of methamphetamine, but there are tools. The DEA is attacking methamphetamine on all fronts, focusing not only on the large scale methamphetamine trafficking organizations, but also those involved in providing the precursor chemicals to fuel these labs. This involves efforts both in enforcement, regulation, and international cooperation.

Additionally, through our office of training we have trained thousands of our State and local partners who are involved in these investigations. Our hazardous waste and victim/witness programs deal with the environmental and societal impacts of methamphetamine.

I want to thank you for your recognition of this important issue and the opportunity to testify here today. I look forward to answering any questions you may have. Thank you.

[The prepared statement of Joseph T. Rannazzisi follows:]

PREPARED STATEMENT OF JOSEPH T. RANNAZZISI, DEPUTY CHIEF, OFFICE OF ENFORCEMENT OPERATIONS, DRUG ENFORCEMENT ADMINISTRATION

Chairmen Gillmor and Deal, Representatives Solis and Brown, and distinguished members of the House on Health and the House Environment and Hazardous Materials Subcommittees, on behalf of Drug Enforcement Administration (DEA) Administrator Karen Tandy, I appreciate your invitation to testify today regarding the "Comprehensively Combating Methamphetamine: Impact on Health and the Environment". I am pleased to testify on the DEA's efforts to combat methamphetamine trafficking and its abuse across the United States.

Methamphetamine's devastating consequences are felt across the country by innocent children and adults, governmental agencies, businesses and communities of all sizes. More commonly known as "meth," this highly addictive stimulant can be easily manufactured using "recipes" available over the Internet and ingredients available at most major retail outlets. While meth used to be associated only with a few outlaw motorcycle gangs (OMG), the use and manufacturing of this deadly sub-

stance is now a national problem. Today few communities in the United States have not been impacted by methamphetamine.

Unlike other, better-known drugs of abuse such as heroin, cocaine, or marijuana, methamphetamine presents some unique challenges. First, it is synthetic, relying on no harvested crops for its manufacture. Unfortunately, the “recipe” to manufacture this synthetic drug is relatively straightforward, and easy to find on the Internet. It can be made using readily available precursor chemicals by anyone who can follow simple instructions. Second, meth has hit rural areas in the United States particularly hard, communities where resources to combat this drug are less available. Third, methamphetamine is a particularly intense stimulant, highly addictive, and overwhelmingly dangerous. The combination of these factors requires a multi-faceted response.

In an effort to combat methamphetamine, the DEA aggressively targets those who traffic in and manufacture this dangerous drug, as well as those who traffic in the chemicals utilized to produce it. We have initiated and led successful enforcement efforts focusing on meth and its precursor chemicals. Everyday the DEA works side by side with our federal, state and local law enforcement partners to combat the scourge of meth. Last spring, DEA Administrator Tandy directed DEA’s Mobile Enforcement Teams (MET) to prioritize methamphetamine trafficking organizations during their deployments. These and other initiatives have resulted in tremendously successful investigations that have dismantled and disrupted high-level methamphetamine trafficking organizations, as well as dramatically reduced the amount of pseudoephedrine illegally entering our country.

The DEA is well aware that combating this drug requires a multi-faceted approach by law enforcement. In addition to our enforcement efforts, the DEA is combating this drug by administering the cleanup of labs across the country, providing assistance to the victims of methamphetamine, and educating communities on the dangers of this drug. The DEA also monitors state legislation aimed at combating methamphetamine and has noted the success experienced by some states in reducing the number of small toxic labs within their borders. Additionally, the Administration supports the development of Federal legislation to fight methamphetamine production, trafficking, and abuse. Any such legislation should balance law enforcement needs with the need for legitimate consumer access to widely-used cold medicines.

METHAMPHETAMINE TRENDS ACROSS THE COUNTRY

The methamphetamine seized and abused in the United States originates from two general sources, controlled by two distinct groups. Most of the methamphetamine found in the United States is produced by Mexico-based and California-based Mexican drug trafficking organizations. These drug trafficking organizations control “super labs” which produce the majority of methamphetamine available throughout the United States. Mexican criminal organizations control most mid-level and retail methamphetamine distribution in the Pacific, Southwest, and West Central regions of the United States, as well as much of the distribution in the Great Lakes and Southeast regions. Mexican midlevel distributors sometimes supply methamphetamine to OMGs and Hispanic gangs for retail distribution throughout the country.

Asian methamphetamine distributors (Filipino, Japanese, Korean, Thai, and Vietnamese) are also active in the Pacific region, although Mexican criminal groups trafficking in “ice methamphetamine” have supplanted Asian criminal groups as the dominant distributors of this drug type in Hawaii. OMGs distribute methamphetamine throughout the country, and reports indicate that they are particularly prevalent in many areas of the Great Lakes region, New England, and the New York/New Jersey region.

The second source for methamphetamine comes from “small toxic laboratories” (STLs), which supplement the supply of foreign manufactured methamphetamine in the United States. Initially found only in the most Western States, there has been a steady increase and eastward spread in the number of STLs found in the United States. Many methamphetamine abusers quickly learn that the drug is easily produced and that it can be manufactured using common household products found at retail stores. For approximately \$100 in “materials”, a methamphetamine “cook” can produce approximately \$1,000 worth of this poison. Items such as rock salt, battery acid, red phosphorous road flares, pool acid, and iodine crystals can be used as sources of the necessary chemicals. Precursor chemicals such as pseudoephedrine can be extracted from common, over-the-counter cold medications, regardless of whether it is sold in liquid, gel, or pill form. Using relatively common items such as mason jars, coffee filters, hot plates, pressure cookers, pillowcases, plastic tubing,

gas cans, etc., a clandestine lab operator can manufacture meth almost anywhere without the need for sophisticated laboratory equipment.

Widespread use of the Internet has facilitated the dissemination of technology used to manufacture methamphetamine in STLs. This form of information sharing allows wide dissemination of these techniques to anyone with computer access. Aside from marijuana, methamphetamine is the only widely abused illegal drug that is capable of easily being produced by the abuser. Given the relative ease with which manufacturers “cooks” are able to acquire “recipes”, ingredients, and the unsophisticated nature of the production process, it is not difficult to see why this highly addictive drug has spread across America.

STLs produce relatively small amounts of methamphetamine from a few grams to several ounces and are generally not affiliated with major drug trafficking organizations. Despite this, STLs still have an enormous impact on local communities, especially in rural areas.

A precise breakdown is not available, but current drug and lab seizure data suggests that roughly two-thirds of the methamphetamine used in the United States comes from larger labs, increasingly in Mexico, and that approximately one-third of the methamphetamine consumed in this country comes from the small, toxic laboratories.

METHAMPHETAMINE AND PRECURSOR CHEMICAL INITIATIVES

The DEA is continuing to investigate, disrupt and dismantle major methamphetamine trafficking organizations through the Consolidated Priority Target list (CPOT) and our Priority Target Organization investigations (PTO). The DEA is significantly involved in the Organized Crime Drug Enforcement Task program (OCDETF) and we continue to work with state and local law enforcement agencies across the country to combat methamphetamine. Additionally, in March 2005, Administrator Tandy directed the DEA's Mobile Enforcement Teams (MET) to prioritize methamphetamine trafficking organizations during their deployments.

The DEA is striving to ensure that only legitimate businesses with adequate chemical controls are licensed to handle bulk pseudoephedrine and ephedrine in the United States. In the past seven years, over 2,000 chemical registrants have been denied, surrendered, or withdrawn their registrations or applications as a result of DEA investigations. Between 2001 and 2004, DEA Diversion Investigators physically inspected more than half of the 3,000 chemical registrants at their places of business. We investigated the adequacy of their security safeguards to prevent the diversion of chemicals to the illicit market, and audited their recordkeeping to ensure compliance with federal regulations.

The DEA is also working with our global partners to target international methamphetamine traffickers and to increase chemical control efforts abroad. The DEA has worked hand in hand with our foreign law enforcement counterparts, and has forged agreements to pre-screen pseudoephedrine shipments to ensure that they are being shipped to legitimate companies for equally legitimate purposes. An example of our efforts is an operation we worked with our counterparts from Hong Kong, Mexico and Panama, to prevent approximately 68 million pseudoephedrine tablets from reaching “meth cartels”. This pseudoephedrine could have produced more than two metric tons of methamphetamine.

As a result of these efforts and those of our law enforcement partners, we have seen a dramatic decline in methamphetamine “super labs” in the U.S. In 2004, 55 “super labs” were seized in the United States, the majority of which were in California. This is a dramatic decrease from the 246 “super labs” seized in 2001. This decrease in “super labs” is largely a result of DEA's enforcement successes against suppliers of bulk shipments of precursor chemicals, notably ephedrine and pseudoephedrine. Law enforcement has also seen a huge reduction in the amount of pseudoephedrine, ephedrine, and other precursor chemicals seized at the Canadian border.

In October 2004, the Administration released the National Synthetic Drugs Action Plan. In this plan, the Department of Justice, the DEA and ONDCP proclaimed the seriousness of the challenges posed by methamphetamine-along with other synthetic drugs and diverted pharmaceuticals-as well as our resolve to confront those challenges. Part of the National Synthetic Drugs Action Plan (NSDAP) specifically recognized that the move of large labs to Mexico requires that we offer assistance to help Mexico strengthen its anti-methamphetamine activities. This, in turn, requires us to work with other countries known to supply Mexican methamphetamine producers with illicit pseudoephedrine. A Synthetic Drugs Interagency Working Group (SD-IWG), co-chaired by the White House Office of National Drug Control Policy (ONDCP) and the Department of Justice (DOJ), was directed to oversee implemen-

tation of the Action Plan. The working group was tasked with reporting their findings to the Director of National Drug Control Policy, Attorney General, and Secretary for Health and Human Services six months after the document's release. In the May 2, 2005 Interim Report the SD-IWG has responded to this portion of the Action Plan:

- China (particularly Hong Kong) has been a significant source of pseudoephedrine tablets that have been diverted to methamphetamine labs in Mexico. The United States and Mexico have obtained a commitment by Hong Kong not to ship chemicals to the United States, Mexico, or Panama until receiving an import permit or equivalent documentation and to pre-notify the receiving country before shipment.
- The United States has made significant progress in assisting Mexican authorities to improve their ability to respond to methamphetamine laboratories. The DEA has played a role by providing diversion and clandestine lab cleanup training courses for Mexican officials (both Mexican Federal and State levels).
- In conjunction with our joint efforts, Mexico this year began to impose stricter import quotas for pseudoephedrine, tied to estimates of national needs and based on extrapolations from a large population sample. Additionally, distributors have agreed to limit sales of pseudoephedrine to pharmacies, which in turn will sell no more than approximately nine grams per transaction to customers.

OTHER APPROACHES TO CONTROLLING METHAMPHETAMINE

Methamphetamine is a synthetic central nervous system stimulant that is classified as a Schedule II controlled substance. It is widely abused throughout the United States and is distributed under the names "crank", "meth", "crystal" and "speed". Methamphetamine is commonly sold in powder form, but has been distributed in tablets or as crystals ("glass" or "ice"). Methamphetamine can be smoked, snorted, injected or taken orally. The clandestine manufacture of methamphetamine has been a concern of law enforcement officials since the 1960's, when outlaw motorcycle gangs produced their own methamphetamine in labs, and dominated distribution in the United States. While clandestine labs can produce other types of illicit drugs such as PCP, MDMA, and LSD, methamphetamine has always been the primary drug manufactured in the vast majority of drug labs seized by law enforcement officers throughout the nation.

A number of states have recently pursued legislation to curtail access to pseudoephedrine products and similar meth precursors. Different states have taken very different approaches to this challenge based upon their understanding of their own unique situation, and of the balance appropriate for their circumstances between law enforcement needs and consumer access to cold medications.

In April 2004 Oklahoma enacted the first and the most far-reaching state law restricting the sale of pseudoephedrine products. This law made pseudoephedrine a Schedule V Controlled Substance. Provisions of this law included the following: limiting sales of both single-entity and combination pseudoephedrine products to pharmacies; requiring pseudoephedrine products to be kept behind the pharmacy counter; and requiring the purchaser to show identification and sign a log sheet.

Oklahoma's law was noted in the National Synthetic Drugs Action Plan, and was the first of many similar proposals introduced in State legislatures last year. The Interim Report again noted Oklahoma's law, as well as the State of Oregon's approach to restrict the sale of pseudoephedrine products. In October 2004, Oregon adopted a similar approach to Oklahoma's model through a temporary administrative rule. However, unlike Oklahoma, Oregon allowed combination pseudoephedrine products—those containing pseudoephedrine plus other active medical ingredients—to be sold at stores other than pharmacies, provided that the products were kept in a secure location. At the time of the Interim Report's release, only four months of data were available for review. This review showed an approximate 42 percent reduction in the number of labs seized from the same months in the prior year. A review of 12 month's worth of data from Oklahoma showed a 51 percent reduction in lab seizures (April 2004 through March 2005).

The Interim Report noted that even with the stabilization in methamphetamine laboratory numbers observed nationally, no states with consistently significant numbers of methamphetamine labs have seen the reductions in lab numbers that took place in Oklahoma and to a lesser but still significant extent in Oregon. The Interim Report stated that the available data (—a year's worth of data from Oklahoma, four months of data from Oregon, and several years worth of national data)—strongly suggested that Oklahoma's and Oregon's state-level approaches were likely the primary reasons for the dramatic reduction in the number of STLs found in Oklahoma, as well as smaller reductions found in Oregon. Since the release of the Interim Re-

port, the State of Oregon has enacted legislation which made pseudoephedrine a Schedule III Controlled Substance.

Since the release of the Interim Report, the seizure of meth labs in Oklahoma has continued to remain at low levels, with a total of 115 meth labs being seized from April through July 2005. The seizure of these 115 labs is significantly less than the seizures reported in Oklahoma during this same time period in 2004 (261) and 2003 (423).

Furthermore, the State of Oregon has recently enacted legislation that classifies pseudoephedrine as a Schedule III Controlled Substance. This law will not go into full effect until July of 2006, and we cannot draw any conclusions about this new measure's effectiveness.

Other states have since passed laws as well, some taking the Oklahoma approach and others taking a variety of less stringent approaches. As data from these states become available, it will be possible to assess the effectiveness of their efforts.

COMBATING METHAMPHETAMINE AND ITS EFFECTS

Pseudoephedrine and ephedrine are List I chemicals which are more correctly known as "listed precursor chemicals" under the Controlled Substances Act. These are chemicals needed and used to manufacture a controlled substance. Any importer of a List I chemical must notify the DEA in advance of importation. However, once the shipment arrives, its ultimate pre-production consumer may not be the recipient identified initially by the importer. The company who placed the order may determine its needs were less than originally anticipated. For the chemical importer this means any excess not sold to the ordering company may then, legitimately, be placed on the "spot" market and sold. Unlike Schedule I and II controlled substances, List I chemicals are not subject to the same stringent record keeping requirements which track the substance from production to consumption, so neither the seller nor buyer on the "spot" market is mandated to report the sale. The only requirement is that the seller maintains a record of the transaction. Tighter regulation of the "spot" market could reduce the amount of ephedrine and pseudoephedrine diverted from legitimate production needs.

Additionally, legislation that would deal with the blister pack exemption and transaction limits would be useful. Elimination of the blister pack exemption would require all products containing ephedrine or pseudoephedrine, regardless of how it is packaged or the form the dosage unit takes, to be subject to Federal law. The enactment of legislation closing this loop-hole will make it more difficult for meth traffickers and "cooks" to get the amount of ephedrine or pseudoephedrine they need for a cook. In addition, effective Federal legislation should include an individual purchase limit of 3.6 grams per transaction for retail sales of over-the-counter products containing pseudoephedrine. Such limits would directly impact the production of methamphetamine in STLs.

TRAINING

In response to the spread of labs across the country, more and more state and local law enforcement officers require training to investigate and safely dismantle these labs. Since 1998, the DEA has offered a robust training program for our state and local law enforcement partners. The DEA, through our Office of Training, provides basic and advanced clandestine laboratory safety training for state and local law enforcement officers and Special Agents at the DEA Clandestine Laboratory Training Facility. DEA instruction includes the Basic Clandestine Laboratory Certification School, the Advanced Site Safety School, and the Clandestine Laboratory Tactical School. Each course exceeds Occupational Safety Health Administration (OSHA)-mandated minimum safety requirements and is provided at no cost to qualified state and local law enforcement officers. As part of this training, approximately \$2,200 worth of personal protective equipment is issued to each student, allowing them to safely investigate and work in this hazardous environment.

The DEA has trained more than 9,300 State and local law enforcement personnel (plus 1,900 DEA employees), since 1998, to conduct investigations and dismantle seized methamphetamine labs and protect the public from its toxic waste.

The Office of Training also provides clandestine laboratory awareness and "train the trainer" programs that can be tailored for a specific agency's needs, with classes ranging in length from one to eight hours. We provide in-service training and seminars for law enforcement groups, such as the Clandestine Laboratory Investigator's Association and the International Association of Chiefs of Police. DEA also has provided training to our counterparts overseas regarding precursor chemical control, investigation and prosecution. This DEA training is pivotal to ensuring safe and effi-

cient cleanup of methamphetamine lab hazardous waste and the arrest and prosecution of violators.

HAZARDOUS WASTE CLEANUP

When a federal, state or local agency seizes a clandestine methamphetamine laboratory, Environmental Protection Agency regulations require the agency ensure that all hazardous waste materials are safely removed from the site. In 1990, the DEA established a Hazardous Waste Cleanup Program to address environmental concerns from the seizure of clandestine drug laboratories. This program promotes the safety of law enforcement personnel and the public by using qualified companies with specialized training and equipment to remove hazardous waste. Private contractors provide hazardous waste removal and disposal services to the DEA, as well as to state and local law enforcement agencies.

VICTIM WITNESS ASSISTANCE PROGRAM

More than any other controlled substance, methamphetamine trafficking endangers children through exposure to drug abuse, neglect, physical and sexual abuse, toxic chemicals, hazardous waste, fire, and explosions. In response to these tragic phenomena, the DEA has enhanced its Victim Witness Program to identify, refer, and report these incidents to the proper state agencies. Each of the DEA's Field Divisions has a Victim/Witness Coordinator to ensure that all endangered children are identified and that the child's immediate safety is addressed at the scene by appropriate child welfare and health care service providers. Assistance has also been provided to vulnerable adults, individuals of domestic violence, and to customers and employees of businesses such as hotels and motels where methamphetamine has been produced or seized.

CONCLUSION

Methamphetamine continues to take a terrible toll on this country. To combat this poison, the DEA is attacking methamphetamine on all fronts. Our enforcement efforts are focused not only on the large-scale methamphetamine trafficking organizations distributing this drug in the U.S., but also on those involved in providing the precursor chemicals necessary to manufacture this poison. The DEA is well aware of the importance of controlling the precursor chemicals necessary to produce methamphetamine and is working with our international counterparts to forge agreements to control the flow of these chemicals.

We are also working closely with our state and local law enforcement partners to assist in the elimination of the small toxic labs that have spread across the country. The DEA's Hazardous Waste Program, with the assistance of grants to state and local law enforcement, supports and funds the cleanup of a majority of the laboratories seized in the United States. The DEA has also taken an active role in the Victim Witness Assistance Program to assist methamphetamine's victims educating communities about the dangers of meth and other illicit drugs.

There are no easy answers to combating the spread of methamphetamine, but there are tools. The best weapon in our collective arsenal is knowledge. We must continue to make our youth better understand how methamphetamine can devastate their lives and harm their bodies. We must help law enforcement officers increase their tactical knowledge of how to effectively identify and attack meth traffickers, and thereby remove incentives for people to manufacture and sell methamphetamine. We must also improve public awareness of how methamphetamine tears apart communities, friendships, and families.

Thank you for your recognition of this important issue and the opportunity to testify here today. I will be happy to answer any questions.

Mr. DEAL. Thank you. And Mr. Murtha?

STATEMENT OF PETER MURTHA

Mr. MURTHA. Chairmen Deal and Gillmor, my name is Peter Murtha. I am the Director of the Office of Criminal Enforcement, Forensics and Training, of the United States Environmental Protection Agency. In that capacity, I direct EPA's criminal enforcement role in responding to human health and environmental threats, including those posed by methamphetamine production.

Thank you for inviting me to appear today to discuss the agency's efforts regarding enforcement issues associated with methamphetamine production, in particular H.R. 3888, the Methamphetamine Epidemic Elimination Act. We commend the Committee for proposing steps to eliminate methamphetamine labs.

My testimony today will describe in general EPA's criminal enforcement experience with methamphetamine labs. I will summarize my statement but ask that my entire written statement be submitted to the record.

EPA's criminal enforcement program investigates those violations of environmental laws that pose both a significant threat to human health and the environment, and manifest the requisite criminal intent.

EPA Criminal Investigation Division offices throughout 15 Area Offices and 29 Resident Offices are spread across the country. EPA participates nationwide in dozens of environmental crime taskforces in nearly every judicial district. Our partners in these taskforces consist of other Federal law enforcement agencies, including the DEA, Offices of the U.S. Attorney, as well as State and local law enforcement and regulatory agencies. EPA works with many of these partners in their efforts to arrest and prosecute producers of methamphetamine who not only violate State and Federal narcotics laws but also Federal hazardous waste laws.

As a law enforcement matter, regulation of methamphetamine labs falls primarily within the jurisdiction of other Federal, State, and local law enforcement agencies. EPA, however, does have authority to investigate environmental crime, usually un-permitted disposal of RCRA hazardous waste associated with such labs.

It is our experience that in cases involving methamphetamine laboratories, the drug, racketeering and conspiracy charges generally brought are typically easier to prosecute and yield far greater sentences than environmental crimes. Thus, in many instances EPA's investigation of methamphetamine laboratories would have limited incremental value, especially in light of resource constraints.

However, EPA continues to coordinate with our Federal, State, and local law enforcement partners to assist in such cases. And EPA stands ready to assist our law enforcement partners by investigating these crimes.

Identifying and cleaning up the vast majority of methamphetamine labs is done by local and State governments. EPA does respond in a small percentage of cases, when local or State resources cannot address the problem. In addition to EPA cleanup response, the agency provides training for thousands of State and local responders each year. EPA offers a wide range of technical and management courses designed to aid responders in identifying and implementing appropriate actions to eliminate the threats from hazardous substances.

The Agency also provides financial support to State, tribal, and local governments and nonprofit organizations that can be used to eradicate and clean up meth labs. Local governments can receive help paying for emergency response actions through EPA's Local Governments Reimbursement Program. EPA also makes funding available to State and local governments for the assessment and

cleanup of meth lab sites through the Office of Brownfields Cleanup and Redevelopment.

EPA's regulations established two ways of identifying solid waste as hazardous under the Resource Conservation and Recovery Act. A waste is hazardous if it exhibits certain characteristic properties, known as characteristics. RCRA regulations define four hazardous waste characteristics: ignitability, corrosivity, reactivity, and toxicity.

The second approach used by EPA is to conduct a specific assessment of a waste or category of wastes and list them as hazardous if the wastes pose substantial hazards. It is very unusual, though not unprecedented, in EPA's experience for an investigation of a methamphetamine lab to reveal neither characteristics nor listed hazardous wastes. Nearly every investigation of methamphetamine labs reveals either characteristic or listed waste.

Mr. Chairman, that concludes my oral statement. We look forward to working with the Committee and its members as it continues to consider this legislation and provide the Committee with any needed technical assistance. Thank you for the opportunity to appear before you today.

[The prepared statement of Peter Murtha follows:]

PREPARED STATEMENT OF PETER MURTHA, DIRECTOR, OFFICE OF CRIMINAL ENFORCEMENT, FORENSICS AND TRAINING, OFFICE OF ENFORCEMENT AND COMPLIANCE ASSURANCE, U.S. ENVIRONMENTAL PROTECTION AGENCY

Mr. Chairman and Members of the Subcommittee, my name is Peter Murtha. I am the Director of the Office of Criminal Enforcement, Forensics and Training in the Office of Enforcement and Compliance Assurance at the Environmental Protection Agency (EPA). In that capacity, I direct EPA's criminal enforcement role in responding to human health and environmental threats, including those posed by methamphetamine production. Thank you for inviting me to appear today to discuss the Agency's efforts regarding enforcement issues associated with methamphetamine production, in particular HR 3889, the Methamphetamine Epidemic Elimination Act. We commend the Committee for proposing steps to eliminate methamphetamine labs. My testimony today will describe in general EPA's criminal enforcement experience with methamphetamine labs.

EPA'S CRIMINAL ENFORCEMENT PROGRAM

EPA's criminal enforcement program investigates those violations of environmental laws that both pose a significant threat to human health and the environment, and manifest the required criminal intent. The program provides state-of-the-art training to our employees and our partners in international, federal, tribal, state, local law enforcement, regulatory and intelligence agencies. EPA's Office of Criminal Enforcement, Forensics and Training administers this program through its Criminal Investigation Division.

EPA Criminal Investigation Division offices are located in 15 Area Offices and 29 Resident Offices throughout the country. EPA participates nationwide in dozens of environmental crime task forces. Our partners in these task forces consist of other federal law enforcement agencies, Offices of the U.S. Attorney, as well as state and local law enforcement and regulatory agencies. EPA works with many of these partners in their efforts to arrest and prosecute producers of methamphetamine who not only violate state and federal narcotics laws but also federal hazardous waste laws.

As a law enforcement matter, regulation of methamphetamine labs fall primarily within the jurisdiction of other federal, state and local law enforcement agencies. EPA does, however, have authority to investigate environmental crimes relating to such labs (e.g., the unpermitted disposal of RCRA hazardous waste).

It is our experience that in cases involving methamphetamine laboratories, the drug, racketeering and conspiracy charges generally brought are typically easier to prosecute and yield far greater sentences than environmental crimes. Thus, in many instances EPA's investigation of a methamphetamine laboratory would have limited incremental value.

EPA continues to coordinate with our federal, state and local law enforcement partners to assist in such cases, while ensuring that they are investigated and prosecuted in the most appropriate manner, which is often not as federal criminal environmental crime cases. At the same time, however, in those unusual cases in which the environmental crimes, rather than the traditional drug prosecution, is the best prosecutive option, EPA stands ready to assist our law enforcement partners by investigating these crimes.

EMERGENCY RESPONSE

Each year, more than 20,000 emergencies involving the release, or threatened release, of oil and hazardous substances are reported in the United States, potentially affecting both large and small communities and the surrounding natural environment. Reports in the local news often report the timely, effective response of local firefighters and other emergency officials. Behind the scenes, however, an integrated National Response System (NRS) involving federal, state, and local officials is at work supporting the men and women on the front lines.

The U.S. Environmental Protection Agency plays a leadership role in this national system, chairing the National Response Team and directing its own Emergency Response Program. In the instances when EPA has had to respond to the risks posed by meth labs, it has been through EPA's Emergency Response Program. The Program's primary objectives are taking reasonable steps to prevent emergencies involving hazardous substances and oil; preparing emergency response personnel at the federal, state, and local levels for such emergencies; and responding quickly and decisively to such emergencies wherever and whenever they occur within our national borders.

METHAMPHETAMINE LABS—EPA'S ROLE

Identifying and cleaning up the vast majority of methamphetamine labs is done by local and state governments, and methamphetamine labs do not generally involve scenarios that would trigger response under the Superfund law. EPA does respond in that small percentage of cases when local or state resources cannot address the problem. In addition to EPA cleanup response, the Agency provides training for thousands of state and local responders each year. EPA offers a wide range of technical and management courses designed to aid responders in identifying and implementing appropriate actions to eliminate the threats from hazardous substances.

The Agency also provides financial support to state, tribal and local governments and nonprofit organizations that can be used to eradicate and clean up meth labs. Local governments can receive help paying for emergency response actions through EPA's Local Governments Reimbursement Program. To date, EPA has provided local governments more than \$3 million through this program. EPA also makes funding available to state and local governments for the assessment and cleanup of meth lab sites through the Office of Brownfields Cleanup and Redevelopment via grants of up to \$200,000 per site. State and local governments can receive grants up to \$1 million to be used for the capitalization of revolving loan funds; they can then make loans and subgrants for the cleanup of methamphetamine labs sites. State and tribal grants provided under CERCLA Section 128 for the development and enhancement of state and tribal response programs can also be used in this regard. And, nonprofit organizations are also eligible for cleanup grants to remediate meth lab sites, also up to \$200,000 per site.

WASTES RESULTING FROM THE PRODUCTION OF METHAMPHETAMINE

EPA's regulations establish two ways of identifying solid wastes as hazardous under the Resource Conservation and Recovery Act (RCRA). A waste is hazardous if it exhibits certain hazardous properties (known as "Characteristics"). RCRA regulations define four hazardous waste Characteristics: ignitability, corrosivity, reactivity, or toxicity. Waste generators are responsible for determining if their wastes exhibit any of the Characteristics through specific tests or general knowledge of the wastes. The second approach used by EPA is to conduct a specific assessment of a waste or category of wastes and "list" them as hazardous if the wastes pose substantial hazards. The listings include wastes generated from various industrial processes, as well as lists of commercial chemical products and other materials.

There are a variety of methods for making methamphetamine. In general many of the chemicals and wastes likely to be associated with methamphetamine production may be addressed as hazardous waste under RCRA, typically as "characteristic" (e.g., ignitable) hazardous waste. A relatively smaller number of the wastes associated with methamphetamine production, including solvents and other chemicals used in the purification of crude methamphetamine products would also be consid-

ered hazardous waste based upon a listing as discarded commercial chemical products. Nearly every investigation of a methamphetamine lab reveals either characteristic or listed hazardous waste.

CONCLUSION

While the response to methamphetamine labs is led principally by local and state efforts, EPA's criminal enforcement program works with local, state, and other federal law enforcement agencies in limited, appropriate cases to investigate and prosecute criminals involved in the production of methamphetamine. EPA will continue to help local, state and other federal agencies address the problems associated with methamphetamine production, ensuring an appropriate law enforcement response. While we anticipate having few such cases in the future, we are ready to assist in those cases that require our participation, such as those with significant environmental impacts or no better prosecutorial option.

We look forward to working with the Committee and its Members as it continues to consider this legislation and provide the Committee with any needed technical assistance. Thank you for the opportunity to appear before you today.

Mr. SHIMKUS [presiding]. Thank you. Now we will begin our opening round of questions and I will start with myself, since I didn't do an opening statement. And we want again welcome you. This is, as has been heard from many of my colleagues, a very difficult problem. I am interested, though—I represent rural Illinois. And of course, we are—our effect is all of the above of what was stated. There is mostly small labs of common household products that are produced anywhere from inside a cornfield to inside a national forest to anywhere where they can be out of sight, out of mind. And the first question would be for the individuals from EPA. What, if any, assistance is there for the local communities once they find a site—a small—not a superlab, but a small site that might be on a—you know, I have seen photos of—Shawnee National Forest is in my district. So there are some picnic areas that are isolated that are used during the good seasons and then pretty much not in the off season. And then you have on this picnic table and this village around there all the, you know, pseudoephedrine and you have the gasoline and all this other, you know, nasty chemicals that are getting kicked around and dropped. What, if any, assistance to local authorities is there from the EPA on the cleanup of this?

Mr. MURTHA. Thank you for the question. Ordinarily, the State and local authorities, being the first line of response, are able to deal effectively with those types of situations. However—

Mr. SHIMKUS. Well, in essence, they are not. In essence—you are talking about HazMat. I have got one rural county that has 5,000 residents in it. So you are really talking about a HazMat team that has to be deployed. Now what we have been able to do in the State of Illinois is, you know, work through the Illinois State Police to provide that and provide some assistance because I am sure if you follow the sheriff's testimony, it is the local rural sheriffs, and I have 30 of them, that are screaming because they can't do it. They don't have the equipment. They don't have—now I think we are all—we are being helped on some training. But it is that challenge. So I am not being combative, it is just a frustration that in Rural America you hear that these are identified as a, you know, chemically polluted site, which again, in very small rural counties there is just not the resources to meet that. So that is probably something that hopefully we—I am on the taskforce to deal with the methamphetamine in the caucus, those things that we are trying

to raise at the legislative level for some assistance. The—I am also concerned about the supersites, these—the testimony talked about, I don't know, two-thirds of the product being in supersites, mostly from Mexico. What is the—I shudder to ask this question, because I think I know the answer. But what is the transportation route, the entry route to the United States?

Mr. RANNAZZISI. Sir, it is all across the Southwest border. For instance, we know that there is one transportation route that goes up through Arizona. It is interesting. Arizona has shown a decrease in clandestine labs over the last 2 or 3 years. The reason we believe the decrease is there is because the market is flooded because that is where that transportation route is. And wherever there is a transportation route, there is going to be a market of methamphetamine. So it is basically along the Southwest border. It is coming across. We still have superlabs in the U.S. We just don't have the amount we had back in 2001. I think we seized about 246 superlabs in 2001. Those are labs that were producing more than 10 pounds of methamphetamine in a 24-hour period. In 2004, we only seized 55. So obviously the population of superlabs has gone down. It has been moved across the border, basically.

Mr. SHIMKUS. And one of the follow-up questions I am going to ask for the next panel is the challenges of the different State laws and application, and probably the same thing with the law enforcement concerns. As we heard earlier in some opening statements, there is obviously a very positive signal of trying to get the handle around—trying to restrict appropriately the purchase of some of the supplies so that it makes it more difficult. But then there is a race and there is disarray in nature and everyone lives, for the most part, unless you are from the State of Hawaii, bordering some other State. And so there is this challenge. In the State of Illinois, they have placed restrictions on the sale of some of these products in flea markets and the like. I bring that to your attention because I know in some States that may not be the case. And is that a venue by which the DEA, working with local law enforcement, are looking at? Obviously that is challenging because the DEA, like any other agency, is a small agency, and—smaller, and we could always use more people and more money. So what about this aspect of purchasing some of these products in the quantities that raise alarm bells that the purchaser is using it for other purposes than just their own personal cold?

Mr. RANNAZZISI. Well, to start, obviously pseudoephedrine products, the cold preparations, could be purchased just about anywhere. We have seen them in, of course, pharmacies, retail outlets, gas stations, liquor stores. It runs a gamut. Now I heard about the flea market sales not but a couple of days ago. And we are starting to look into that to find out about flea market sales. You could purchase it over the Internet. It is readily available. And that is the problem. Now the small traffickers are generally smart. They are not going to go in and buy five or six packages at one store. They—

Mr. SHIMKUS. Well, they are not anymore because of legislation or the requirement by States to identify them. I mean, you go through a major chain store and you swipe the bar scan and all of the sudden bells and whistles go off and local law enforcement is

there. So that has occurred because of an action taken by actually individual States and local law enforcement and really the companies that are, you know, in the basis of selling and—these products, too, legally.

Mr. RANNAZZISI. That is exactly correct, sir. But they are still smurfing. They might not buy more than two packages, but they are going to 20 different retail outlets to get the two packages. Okay? They are slipping under the, you know, they are slipping under the radar screen, basically. The fact is that if the States that are requiring, you know, some kind of identification, the States that are actually keeping the product in a restricted—in some type of restriction, some type of point-of-sale restriction, those are the States that, you know, are seeing a decrease. Yet they are crossing the border to States that don't have those legal restrictions and they are getting the product anyway.

Mr. SHIMKUS. Thank you. And I just want to end. And I will then yield to my colleague from California. As I said, it is an important hearing. It is a scourge, again, in Rural America. And I look forward to the sheriff's testimony. The other challenge that small communities have is the health care costs once they apprehend these individuals, they put them into incarceration. And the physical effects of meth addiction is just—peoples' teeth fall out and there is no bleeding. It is amazing. It is a poison. And local governments have to incur that cost of the health care for the folks in their jails. So we have great challenges and I think that is why all my colleagues are here and very interested in this testimony. And with that, I want to thank you. And I yield to my colleague from California.

Ms. SOLIS. Thank you very much. Before I begin, I would like to ask Mr. Murtha, as a side note, members of our committee sent a letter to Administrator Johnson seeking answers to some refinery issues and we were hopeful to get a response back September 27. I would like to know if you have any information about that or if you could please take that message back, that we would like to get a response.

Mr. MURTHA. I would be delighted to take that message back. I don't know anything about it, regrettably.

Ms. SOLIS. Regarding some refinery issues that we had. So very quickly, I would like to ask you, if you can tell me, Mr. Murtha, what criteria EPA currently uses to determine if a substance is hazardous. You mentioned four—I think four or five items or criteria. But how—can you explain that? And then also tell me how that differs or if there is any difference between the bill that we are discussing, the Souder Bill.

Mr. MURTHA. Well, we primarily have two main approaches, one of which is called characteristic waste, the second of which is called listed waste. All of these are set forth in a great deal of specificity in 40 CFR Part 261, et sec. But basically, the characteristics that I spoke of before, ignitability, corrosivity—

Ms. SOLIS. Yes.

Mr. MURTHA. [continuing] reactivity—

Ms. SOLIS. Um-hum.

Mr. MURTHA. [continuing] those types of things are done by virtue of a testing method—a standardized testing methodology. And

if you have a particular substance, any trained laboratory scientist can make the determination whether or not that criteria fits the particular substance being analyzed. What we have found is that in the substantial majority of our investigations of methamphetamine labs, one or more of the substances we find at those labs can be characterized as hazardous waste. For example, often times solvents are found on the sites. Those are very, very frequently going to be ignitable hazardous wastes. So they come within the universe of RCRA and are regulated as such. And therefore, for example, if they are improperly disposed of or improperly stored, and that is done knowingly, we are in a position where we can actually bring felony charges against that particular individual. The second basic approach is the listing approach. And there is a very—there are several, actually, lengthy tables in the CFR specifying under two different approaches. One approach takes a look at a particular industry and says that all of the waste from this particular industry in connection with this particular process will be deemed hazardous waste. A second approach is to take a look at a particular chemical and indicate that if this chemical product is abandoned or discarded, then that is considered hazardous waste.

Ms. SOLIS. Okay.

Mr. MURTHA. Now, getting back to your original question, what would this do under the provisions suggested in 3888—

Ms. SOLIS. Right. 401(b).

Mr. MURTHA. —89.

Ms. SOLIS. Section 401(b). How would—

Mr. MURTHA. Right.

Ms. SOLIS. How would that differ?

Mr. MURTHA. There may be a rather small segment of cases where for whatever reason neither hazardous waste nor characteristic waste will be found at a methamphetamine lab. I actually asked my staff to take a 10-year retrospective look to see the extent that that has actually happened. And I was actually only able to find a single case where we went in, investigated a lab, took samples, did the things we would ordinarily do in the course of a criminal investigation, yet did not yield any hazardous waste. It is possible that the approach suggested in the bill might allow us to sweep that odd case under the rubric of RCRA. But again, in what we have seen, it has not been a frequent occurrence that we would need that type of additional authority.

Ms. SOLIS. And just to note, I guess in that section it says that all byproducts shall be designated as a hazardous waste, where the Administration determines they are likely to cause long-term harm to the environment in the event of improper disposal and inadequate remediation.

Mr. MURTHA. I am not sure I completely understand the question, ma'am.

Ms. SOLIS. Well, that is part of the section in the bill, H.R. 3889, Section 401(b). And I am wondering how that differed from what you are currently doing.

Mr. MURTHA. Well, once again, it would broaden our authority and would essentially give us the ability in certain but unusual cases where we are unable under our current manner of characterizing and listing hazardous waste to be able to attribute those

characteristics or listings to something we would find at a meth lab site. So it clearly is broader. It could fill in some very occasional gaps that we experience.

Ms. SOLIS. Thank you. Thank you, Mr. Chairman. I know I took more time.

Mr. GILLMOR. I thank the ranking member and wish her a happy birthday. I have a couple questions for Mr. Murtha. Does EPA or any other Federal agency employ voluntary guidelines or mandatory standards in governing the cleanup or remediation of meth contamination sites?

Mr. MURTHA. My understanding, sir, and bearing in mind that my background and position is a bit different, being involved in the Criminal Enforcement Office, is that the Office of Solid Waste and Emergency Response, or OSWER, works in conjunction with the DEA in terms of formulating those types of guidelines.

Mr. GILLMOR. Based on your answer then, if EPA were to issue guidelines on methamphetamines, would that fall under the purview of the Office of Solid Waste and Emergency Response?

Mr. MURTHA. That is correct, sir.

Mr. GILLMOR. All right. Title 4 of H.R. 3889, Section 402, creates a new criteria for cleanup costs under the Controlled Substances Act. It says passage of H.R. 3889 would constitute a later in time enactment. Would these new provisions hamper or amend EPA's efforts at cost recovery for cleanup or remediation of sites under Federal environmental statutes?

Mr. MURTHA. Sir, I think that is a little beyond my immediate expertise. And I would like to have an opportunity to supplement the record with a written response.

Mr. GILLMOR. We would very much appreciate it if you would do that. Thank you. The gentleman from New Jersey.

Mr. PALLONE. I wanted to ask Mrs. Colston, following up on my opening statement. In your testimony you cite that the rates of I guess meth use amongst youth age, 12 to 17, declined from 0.9 percent in 2002 to 0.76 percent in 2003, and dropped again to 0.6 percent in 2004. I mean, I know those numbers are not, you know—they are still pretty close. But I made the point in my opening statement that the Republican Study Committee Budget would seek to eliminate funding for the Drug-Free School Zone Program as well as funding for the Office of the National Drug Control Policy. And that is an office that your agency is working with to develop grassroots community anti-drug coalition. I mean, the Republicans claim that these are programs that are ineffective in preventing and reducing drug use. Can you comment on the efficacy of those programs—these prevention programs and what impact budget cuts might have on them? I know it is a very partisan question, but if you could answer it.

Ms. COLSTON. How about if I answer it within the context of the approach that SAMHSA has taken to address substance abuse prevention, which is very much tailored, allowing communities to tailor prevention interventions based on the needs in the community, rural, urban, whether they are—no matter where they are located. The beauty of our Strategic Prevention Framework is that community prevention, almost by definition, means working across systems to stop drug use. And our Strategic Prevention Framework re-

quires that communities, working with States, actually assess needs, develop a plan, mobilize resources based on these needs, methamphetamine abuse—

Mr. PALLONE. But, I mean, you would certainly not advocate cutting these grants that—

Ms. COLSTON. We have no position on that, sir.

Mr. PALLONE. Okay. Let me ask I guess Mr. Rannazzisi. You know, a number of the State laws that are—have been passed or end up reducing meth abuse. And a lot of them basically limit the supply of either meth or precursors used to manufacture it. And despite these efforts, the meth problem continues to spread as manufacturers and, you know, basically look for alternative methods of obtaining the ingredients that produce meth. And many of the policies introduced in this Congress—many of the bills seek to curb meth abuse once again by focusing on precursor regulation. You know, placing cough medicines behind the shelf, drug stores, you know, trying to get them off the shelf. Have these kinds of efforts that—have they been successful in curbing meth abusers or do those producers look and find other ways to access precursors?

Mr. RANNAZZISI. Well, we can look at two States that were mentioned in the report for the National Synthetic Drug Action Plan. Oklahoma basically passed Schedule 5 legislation, reduced their lab seizures by 52 percent. Oregon—and that was a full year data set, so we had a full year data set. Oregon, in the first 4 or 6 months of their law, which was similar to Schedule 5, with the exception of combination pseudoephedrine products could be sold behind the counter at other retail outlets, had about a 42 percent reduction. So obviously in those States they have showed a significant reduction in clandestine labs. However, you could go to the neighboring States to make your purchases of pseudoephedrine and bring them back across the border. And in Oklahoma they were seeing that pretty regularly.

Mr. PALLONE. So you would argue that we need to do things federally so that we can't have, you know, shopping at different States or neighboring States because the one State passed a certain law. Is that—you think the most important thing is to have Federal action?

Mr. RANNAZZISI. What we need to—well, the Attorney General, Secretary Levin, and Director Walters I think laid out what they feel—what the Administration feels is a good response legislatively, a 3.6 gram limit on the number of—on the amount of purchase for at retail level. The removal of the blister pack exemption, the so-called Safe Harbor Provision, so you could purchase unlimited amounts of pseudoephedrine blister packs without any kind of record of a transaction. And finally, the spot market removal. There is a loophole in the law that allows importers to—if an importer brings in an amount of pseudoephedrine for a company and that company decides they don't want it, the importer could basically sell it to anybody, whereas that importer is granted the right to import based upon who the downstream purchaser of that product is. So the Administration laid out those three specific provisions that would help in the—combating methamphetamine manufacturing.

Mr. PALLONE. All right. Thank you.

Mr. GILLMOR. The gentleman from Texas.

Mr. BURGESS. Yes, Mr. Chairman. With your indulgence, I did have a few questions. Ms. Colston, why is methamphetamine so bad?

Ms. COLSTON. That is a good question, sir. I think methamphetamine is so bad because it is so highly addictive. The people that we are seeing in our treatment system now are dependent. They have been abusing methamphetamine for over 7½ years. But—

Mr. BURGESS. Let me interrupt for just a moment. Mr. Chairman, I waived the right to an opening statement and I wonder if I might be given the—

Mr. GILLMOR. The gentleman is recognized.

Mr. BURGESS. Thank you. But I wonder if I might be recognized for the 8 minutes rather than 5.

Mr. GILLMOR. The gentleman is recognized for the 8 minutes. I would point out to the members, we are going to have a problem here with the—

Mr. BURGESS. I understand.

Mr. GILLMOR. [continuing] but the gentleman did waive, so—

Mr. BURGESS. Thank you.

Mr. GILLMOR. [continuing] the gentleman is entitled to his 8 minutes.

Ms. COLSTON. Methamphetamine has profound cognitive impact. That is why when people present for treatment it is very important to take a cognitive behavioral approach. That is, a very comprehensive approach and work on just the fact that someone doesn't have the ability to make a decision.

Mr. BURGESS. Well, if I may interrupt—

Ms. COLSTON. Sure.

Mr. BURGESS. [continuing] what are some of the treatments for someone who is addicted to methamphetamine? Do we have a—

Ms. COLSTON. Yes, sir.

Mr. BURGESS. [continuing] like a Methadone for heroin? What—

Ms. COLSTON. We—

Mr. BURGESS. [continuing] are some of the things—

Ms. COLSTON. [continuing] we have an approach that has positive outcomes, called the Matrix model, which I referred to earlier. And it has cognitive behavioral aspects, family education, daily living skill, initially work on the more intensive end—when they first come in, more intensive treatment and then clinical treatment and then move through the recovery support services, because it is a long-term issues.

Mr. BURGESS. So this requires primarily psychotherapy. There is no pharmacological therapy, such as Antabuse or Methadone—

Ms. COLSTON. Correct.

Mr. BURGESS. [continuing] that would be useful in the treatment of—

Ms. COLSTON. Correct. At this point, yes.

Mr. BURGESS. [continuing] addiction. Well, how effective is that regiment of psychotherapy and family therapy that you have?

Ms. COLSTON. We have had very good results, between 57 and 68 percent of the Matrix model system reported no methamphetamine use at discharge and at follow-up points after—

Mr. BURGESS. 57 percent?

Ms. COLSTON. Yes, sir.

Mr. BURGESS. Over what period of time?

Ms. COLSTON. At discharge and at certain points after discharge.

Mr. BURGESS. How long is that—

Ms. COLSTON. It is likely to get better.

Mr. BURGESS. How long—okay. What sort of time—

Ms. COLSTON. Six points, 1 year.

Mr. BURGESS. Okay.

Ms. COLSTON. Six months.

Mr. BURGESS. What—

Ms. COLSTON. And they also have improvement in their employment status, family relations, legal status.

Mr. BURGESS. Sure. And I understand that. I mean, I have personally witnessed in my own medical practice—

Ms. COLSTON. Yes.

Mr. BURGESS. [continuing] how disruptive this is to a family. Well, how expensive is the treatment then, the psychotherapy, family therapy that you have outlined?

Ms. COLSTON. I would have to get that information to you. I do not have the exact cost information with me today.

Mr. BURGESS. If you could. And I don't—

Ms. COLSTON. I will absolutely do that.

Mr. BURGESS. [continuing] I don't know if it is even available to break it down as cost per patient or cost per month.

Ms. COLSTON. Yes, sir.

Mr. BURGESS. And then do you have—does SAMHSA keep any sort of record as far as oversight for who is doing the best job with this, who has got the best rates, so we try to capture some best practices? Because being of a more practical sort—

Ms. COLSTON. Yes.

Mr. BURGESS. [continuing] when I hear about things that are treated with psychotherapy and family therapy, I get a little concerned that there is going to be—the definitions may not be as precise as I might like.

Ms. COLSTON. Yes, sir. We do. We have had a number of years trying to identify evidence-based practices and disseminating that knowledge and information.

Mr. BURGESS. If you would share that with the Committee—

Ms. COLSTON. I absolutely—

Mr. BURGESS. [continuing] I think that would be—

Ms. COLSTON. I absolutely will.

Mr. BURGESS. [continuing] useful information for us—

Ms. COLSTON. Yes, sir.

Mr. BURGESS. [continuing] to have. Let me just ask you this. You said it is—one of its problems is it is so terribly addictive. Would you regard methamphetamine as a gateway drug? Is it one of the things that if someone said you know, today is the day I am going to start my career in drug abuse. I will go out and buy some meth. Is that what is likely to happen?

Ms. COLSTON. I don't think I would characterize it that way, sir. It is such a serious drug in and of itself. And we are doing our best. We actually—I am trying to think about our surveillance data. It—the domestic amphetamine—

Mr. BURGESS. Well, let me ask the question in another way—

Ms. COLSTON. Okay.

Mr. BURGESS. [continuing] then. Would it be more likely that someone would come to the decision to use meth because they were with a group of people who found that they liked it and said you ought to try this?

Ms. COLSTON. Yes, sir.

Mr. BURGESS. Well, would those be people that you might—a younger person or young adult might go out and drink beer with?

Ms. COLSTON. It is possible.

Mr. BURGESS. Is beer perhaps a gateway drug for methamphetamine?

Ms. COLSTON. I am not aware.

Mr. BURGESS. Is marijuana a gateway drug?

Ms. COLSTON. I am not aware of that.

Mr. BURGESS. Has anyone does those studies? Do you think anyone is aware of that?

Ms. COLSTON. Yes, sir. I believe we do have studies and I will be happy to provide them.

Mr. BURGESS. Does the DEA have an opinion on that?

Mr. RANNAZZISI. No, sir.

Mr. BURGESS. The reason I am asking is because all the time we are asked to liberalize our marijuana laws for medical treatment and, you know, you are describing a problem here that is maybe not as horrific as avian flu, but it is pretty horrific in its effect on families. And I think we need to be incumbent upon us as lawmakers to do everything at our disposal, to make certain we have gathered all the tools that are available to ourselves to keep this epidemic from spreading. And Mr. Chairman, I am sensitive to the time. I do want to ask the gentleman from the DEA, I think the technical term that was given by Mr. Shimkus was smurfing. Is that right?

Mr. RANNAZZISI. Yes, sir.

Mr. BURGESS. And you said that to be a successful smurf you can buy no more than 3.5 grams of a precursor agent at a time. Is that correct?

Mr. RANNAZZISI. Depending on the package sizes. Most of them are—most of the people who are smurfing are going in and buying a couple—two or three packages at a time.

Mr. BURGESS. Are you utilizing any of the available pharmaceutical programs for data mining to sort of isolate or identify the person who may be out there buying small quantities to gather enough to make a shipment or a batch?

Mr. RANNAZZISI. Well, the buying in such small quantities and the fact is there are no records—

Mr. BURGESS. I guess that is really the question I am—

Mr. RANNAZZISI. Yeah.

Mr. BURGESS. [continuing] trying to ask. Do we need to ask that those types of records be kept, even for someone coming in and buying a 12-capsule blister pack of pseudoephedrine?

Mr. RANNAZZISI. I believe that record keeping is a useful tool. And—

Mr. BURGESS. Yeah, and I do, too. Of course, one of the difficulties is if we capture all the smurfs and round them up we can drive

the problem offshore. And Republicans are always accused of outsourcing our jobs. And maybe we outsource this to some place else. And what about the border interdiction? How do you think we are doing there?

Mr. RANNAZZISI. The border is—it is very—miles. Hundreds of miles, thousands of miles of border. I—we are doing the best we can at the—

Mr. BURGESS. That—1,200 miles of that 2,000 mile southern border is in my State of Texas.

Mr. RANNAZZISI. Yes, sir.

Mr. BURGESS. All right. I am very familiar with how much is there. Perhaps, again, in the interest of time, you could provide to the Committee what the DEA's opinion is as to how you are doing with interdiction and what you think needs to be increased and what you think needs to be decreased as far as what we are doing, as far as making an effective border control. Because the more we clamp down domestically, I have the feeling we are going to encourage the production outside the country. Certainly that has been the case with some other drugs. And Mr. Chairman, with that, I will yield back.

Mr. GILLMOR. I thank the gentleman. We have a series of votes which has begun on the House floor. And so we are going to have to go over and vote. I would propose that we recess until 1, which will give us time to complete those votes. People can have lunch and we will try to reconvene then. Also, before I recess, I wanted to ask the panel, some members are not here but may have questions. Would you be willing to respond to written questions in writing?

Ms. COLSTON. Of course.

Mr. RANNAZZISI. Yes, sir.

Mr. GILLMOR. I thank you very much.

Mr. MURTHA. Sure thing.

Mr. GILLMOR. And we stand in recess.

[Recess.]

Mr. GILLMOR. I am calling the subcommittee to order. And we will proceed with the first panel. And first of all, let me express my appreciation to all of you for coming. And also, my apologies for the delay in getting to this panel because of the road schedule. But we will proceed with Mr. Eric Coleman, Commissioner of Oakland County, Michigan.

STATEMENTS OF HON. ERIC COLEMAN, COMMISSIONER, OAKLAND COUNTY, MICHIGAN, ON BEHALF OF NATIONAL ASSOCIATION OF COUNTIES; MARY ANN WAGNER, SENIOR VICE PRESIDENT FOR PHARMACY, POLICY, AND REGULATORY AFFAIRS, NATIONAL ASSOCIATION OF CHAIN DRUG STORES; GORDON KNAPP, PRESIDENT, PCH NORTH AMERICA, PFIZER, INC.; TED G. KAMATCHUS, MARSHALL COUNTY SHERIFF'S OFFICE, ON BEHALF OF NATIONAL SHERIFFS' ASSOCIATION; AND JOSEPH R. HEERENS, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS, MARSH SUPERMARKETS, INC., ON BEHALF OF FOOD MARKETING INSTITUTE

Mr. COLEMAN. Thank you, Chairman Gillmor. My name is Eric Coleman. I am a county commissioner from Oakland County,

Michigan. In addition, I currently serve as First Vice President of the National Association of Counties.

The National Association of Counties, or NACo as it is sometimes known, is the only national organization that represents county government. With over 2,000 member counties, we represent over 85 percent of the Nation's population.

A growing issue for counties across the Nation is methamphetamine abuse. Methamphetamine, or meth, is consuming a greater share of county resources because of its devastating and addictive nature. In many parts of the nation, county jails are becoming overwhelmed with inmates on meth related charges who often need greater medical and dental attention. Investigating and busting meth labs is requiring longer hours for county law enforcement personnel. Along with these law enforcement consequences, mass treatment, cleanup, removing children from meth houses are all painful reminders of a community with meth.

To illustrate the severity of the meth crisis, NACo commissioned two surveys on the impact to county government. And I would like to make two points on these surveys and NACo's policy on meth.

First, our survey confirmed meth amphetamine abuse is a national drug crisis that requires national leadership. Second, a comprehensive and governmental approach is needed to combat the meth epidemic. Necessary components must include law enforcement, treatment, child protective services, prevention, education, public health, environmental cleanup, and research and precursor control.

To elaborate, I will briefly touch on NACo's survey on the law enforcement. In the 500 responding State sheriff departments, 87 percent reported increase in meth related arrests starting 3 years ago. 17 States reported 100 percent increase in meth related arrests during the last 3 years, including Ohio and California. In addition, 7 States, including Georgia and Mississippi report a 90 percent increase.

Additionally, 58 percent of the county law enforcement agencies reported that meth is their largest drug problem. Meth outpays cocaine by 19 percent, marijuana by 17 percent, and heroin by 3 percent.

Meth related arrests represent a higher proportion of crime requiring incarceration. 50 percent of the counties surveyed estimated that 1 in 5 in their current jail population are related to meth related crimes. The numbers are increasing so rapidly counties are having a difficult time in wrapping up their services to address the problem.

We also surveyed child welfare officials from 13 States where services are provided by county government. Children living in houses where meth is produced or used are considered drug endangered due to toxin, neglect, and abuse.

40 percent of all children welfare officials surveyed reported increase in out of home placement because of meth in the last year. In addition, 59 percent of county officials reported meth has increased the difficulties of reuniting families.

NACo believes that these figures confirm the need for a comprehensive and intergovernmental strategy to fight this insidious drug. One piece of this puzzle must be precursor control. States

such as Iowa and Oklahoma have seen dramatic reductions in meth labs since implementation of their State legislation. NACo is a supporter for the Combat Meth Act, Senate Bill 103, which was incorporated in the Senate Conference Justice Science Spending Bill. NACo urges the members of the House to accept the Senate's position during the Conference negotiations and enact that legislation.

Additionally, NACo strongly supports House Bill 798, the Methamphetamine Remediation Act. This legislation would direct the EPA to establish standards for cleaning up a former meth lab. Currently, local government and private land owners lack scientifically based standards to clean up former meth labs. We believe that this bill represents a significant step toward understanding the true nature of methamphetamine production and use.

Additionally, NACo has endorsed House Bill 2335, the Meth Endangered Children Protection Act. This legislation would authorize \$10 million annually to assist States and local governments in developing Drug Endangered Children teams. DEC teams are specially trained local law enforcement officials, child protective service workers, medical professionals, and prosecutors that comprehensively respond to the needs of children found in meth labs.

Additional issues that must be addressed by our Congressional Committees include increasing funding for local law enforcement, particular the Justice Assistance Grant Program, mostly prevention funding aided at educating today's youth on the dangers of meth and increasing funding for meth treatment.

In conclusion, I would like to thank you for the opportunity to appear before you today on behalf of NACo. We will be conducting future surveys on meth abuse and look forward to reporting our findings and working with you to resolve the meth crisis in this country. Thank you and I will be happy to answer any questions that you may have.

[The prepared statement of Hon. Eric Coleman follows:]

PREPARED STATEMENT OF HON. ERIC COLEMAN, COMMISSIONER, OAKLAND COUNTY,
MICHIGAN AND FIRST VICE PRESIDENT, NATIONAL ASSOCIATION OF COUNTIES

Thank you Chairman Gillmor, Chairman Deal, Ranking Member Solis and Ranking Member Brown and Members of the Subcommittees. My name is Eric Coleman, I am a County Commissioner from Oakland County, Michigan, and I currently serve as the First Vice President of the National Association of Counties. I have served as a County Commissioner in Oakland County since 1996.

About the National Association of Counties

Established in 1935, the National Association of Counties (NACo) is the only national organization representing county governments in Washington, DC. Over 2,000 of the 3,066 counties in the United States are members of NACo, representing over 85 percent of the population. NACo provides an extensive line of services including legislative, research, technical, and public affairs assistance, as well as enterprise services to its members. The association acts as a liaison with other levels of government, works to improve public understanding of counties, serves as a national advocate for counties and provides them with resources to help them find innovative methods to meet the challenges they face. In addition, NACo is involved in a number of special projects that deal with such issues as the environment, sustainable communities, volunteerism and intergenerational studies.

NACo's membership drives the policymaking process in the association through 11 policy steering committees that focus on a variety of issues including agriculture, human services, health, justice and public safety and transportation. Complementing these committees are two bi-partisan caucuses—the Large Urban County Caucus and the Rural Action Caucus—to articulate the positions of the association.

The Large Urban County Caucus represents the 100 largest populated counties across the nation, which is approximately 49 percent of the nation's population. Similarly, the Rural Action Caucus (RAC) represents rural county commissioners from any of the 2,187 non-metropolitan or rural counties. Since its inception in 1997, RAC has grown substantially and now includes approximately 1,000 rural county officials.

Methamphetamine

Methamphetamine or meth is a highly addictive homemade amphetamine that can be made from commonly found chemicals, such as pseudoephedrine, anhydrous ammonia, lye, phosphorous and antifreeze. Meth is an insidious drug that is cheap to produce that can be easily manufactured in virtually any setting; a car, house or deserted area. The drug can be smoked, snorted, injected or swallowed and releases an intense high for hours. Harmful long-term health risks from meth abuse include tooth and bone loss, damage to the user's brain, liver and kidneys, heart attack and stroke. Children who are exposed to the toxic chemicals during production of methamphetamine can also develop these conditions. In addition, the prolonged use of the drug, called "tweaking", can keep users up for days or weeks at a time. Consequently, the psychological side effects of meth use include paranoia, anger, panic, hallucinations, confusion, incessant talking and convulsions. Many of these lead to violent aggressive acts and suicide.

According to the 2003 National Survey on Drug Use and Health 12.3 million Americans had tried methamphetamine at least once—up nearly 40% over 2000 and 156% over 1996. In 2004, the survey notes that an estimated 1.3 million Americans regularly smoked, snorted or injected the drug.

Historically, meth abuse was confined to the Western United States and to rural areas. However, the drug has quickly spread East and is having disastrous consequences in rural, urban and suburban communities nationwide.

Impacts of Methamphetamine Abuse on County Governments

County governments are on the front-line in dealing with the painful and costly consequences of methamphetamine abuse and production. The United States Drug Enforcement Agency estimates that 65 percent of methamphetamine is produced in "superlabs" in Mexico and California with the remaining 35 percent produced in "small toxic labs". These labs pose a significant risk to their community and represent the largest problem for local law enforcement. Investigating and busting small toxic labs, incarcerating and adjudicating meth users and cleaning up former meth labs are searing a hole in county budgets. County correction facilities are being overwhelmed by the increase in the number of meth related crimes and associated incarceration costs including mental health treatment, dental and other treatment costs. The need for and cost of county public defender services are also increasing at alarming rates because of the meth epidemic.

There are also many societal effects caused by meth abuse. In an alarming number of meth arrests, there is a child living in the home. These children often times suffer from neglect and physical and sexual abuse.

Meth labs pose a significant danger in the community because they contain highly flammable and explosive materials. Local first responders must be trained on how to identify and respond to meth labs in their communities. Additionally, for each pound of methamphetamine produced, five to seven pounds of toxic waste remain, which is often introduced into the environment via streams, septic systems and surface water run-off.

Meth abuse is a complex, difficult, growing problem that must be solved by cooperation among all levels of government and involvement by our citizenry. NACo is in the early stages of a national campaign to fight methamphetamine abuse. The primary objective of this initiative is to promote action by Congress and the Administration to control and reduce the production, distribution and abuse of methamphetamine, including assistance to counties in responding comprehensively to the problem locally. We look forward to working with this committee and your colleagues on this undertaking.

As part of this initiative, NACo President and Umatilla County, Oregon Commissioner Bill Hansell has appointed a cross-cutting work group that has county representatives from all perspectives of the issue. The charge of our Methamphetamine Action Group is to further assess the impacts of meth abuse on county governments, educate county officials and the public on the dangers of the drug and identify best practices and local approaches that address education, prevention, enforcement, cleanup and treatment of meth challenges.

In addition, NACo will be conducting further surveys on other aspects of the methamphetamine crisis. Currently, we just received the raw data for a survey on

the impacts of meth abuse on the treatment delivery system and public health system. We would welcome the opportunity to appear before this committee at a later date to discuss these findings.

This morning, I would like to make two key points:

- First, as NACo's two recent surveys confirmed, methamphetamine abuse is a national drug crisis that requires national leadership.
- Second, a comprehensive and intergovernmental approach is needed to combat the methamphetamine epidemic. Necessary components must include law enforcement, treatment, child protective services, prevention, education, public health, cleanup, research and precursor control. NACo urges Congress to adopt several targeted measures and increase funding to address aspects of the meth crisis—including HR 798, S 103 and HR 2335.

First, as NACo's two recent surveys confirmed, methamphetamine abuse is a national drug crisis that requires national leadership.

On July 5, 2005, NACo released two surveys on the methamphetamine crisis that has swept the nation. In the first survey, entitled, *The Criminal Effect of Meth on Communities*, is based on results from 500 county law enforcement agencies from 45 states. The counties that participated in the survey are representative of all counties nationally based on population and regional representation.

Meth is a growing problem that is now national in scope. Of the 500 responding law enforcement agencies, 87 percent report increases in meth related arrests starting three years ago. The states reporting a 100 percent increase in meth related arrests during the last three years include Indiana, California, Minnesota, Florida and Ohio. Furthermore, Iowa and Mississippi reported a 95 percent increase and Illinois and North Dakota reported a 91 percent increase.

Additionally, 58 percent of county law enforcement agencies reported that meth is their largest drug problem. Meth outpaced cocaine at 19 percent, marijuana at 17 percent and heroin at 3 percent. In certain regions of the country, the percentages are even higher. In the Southwest, 76 percent of the counties said that meth is the biggest drug problem. In the Northwest, 75 percent said it was the top problem and by 67 percent of the counties in the Upper Midwest.

Meth related arrests represent a high proportion of crimes requiring incarceration. Fifty percent of the counties estimated that 1 in 5 of their current jail inmates are there because of meth related crimes. The problem is even worse in the other half of the counties surveyed. Seventeen percent of the counties report that more than half of their populations are incarcerated because of meth related crimes.

Stopping the small meth lab operations continues to be a problem. Concerning lab seizures, 62 percent said that meth lab seizures increased in their counties in the last three years.

Other crimes are increasing because of meth. Seventy percent of the responding officials say that robberies or burglaries have increased because of meth use, while 62 percent report increases in domestic violence. In addition, simple assaults at 53 percent and identity thefts 27 percent have also increased because of meth use.

The increased presence of meth in many counties across the nation has increased the workload of 82 percent of the responding counties. These increased law enforcement activities from meth abuse are straining law enforcement budgets. Fifty-two percent of counties stated that they are paying more overtime, while 13 percent have changed work assignments to accommodate the increase need for policing.

Methamphetamine abuse is beginning to reach my home county, Oakland County, Michigan. The Oakland County Prosecuting Attorney's office reports that since October 2001, their office has processed approximately 30 cases involving either possession or possession with the intent to deliver methamphetamine.

The Impact of Meth on Children

As law enforcement officials are clamping down on the manufacture and use of meth, they are finding a disturbing side effect. Many children are being grossly neglected by their addicted parents and these same children are being exposed to the harmful side effects of the production of the drug if they live in close proximity to a lab.

To assess this problem, NACo surveyed 303 counties from all 13 states where child welfare activities are performed at the county level to assess the danger to children and families from meth abuse.

Forty percent of all the child welfare officials in the survey report increased out of home placements because of meth in the last year. During the past five years, 71 percent of the responding counties in my home state of California reported an increase in out of home placements because of meth and 70 percent of Colorado counties reported an increase. The results in the Midwest are frighteningly similar. More than 69 percent of counties in Minnesota reported a growth in out of home

placements because of meth during the last year, as did 54 percent of the responding counties in North Dakota. In addition, 59 percent of county officials reported meth has increased the difficulty of re-uniting families.

Meth use is not limited to rural counties, nor is it limited to the West and Midwest. As a follow-up to the NACo report, one of our affiliate associations, the National Association of County Human Services Administrators, conducted an informal survey. Sacramento County, California, a large urban county, discovered that meth was involved in 70 percent of the family cases referred to court services due to substance abuse. Wilkes County, North Carolina Child Protective Services reported that methamphetamine abuse has been the most damaging drug to families that they have ever encountered.

Second, a comprehensive and intergovernmental approach is needed to combat the methamphetamine epidemic. Necessary components must include law enforcement, treatment, child protective services, prevention, education, public health, cleanup, research and precursor control. NACo urges Congress to adopt several targeted measures and increase funding to address aspects of the meth crisis—including HR 798, S 103 and HR 2335.

Precursor Control

In April 2004, Oklahoma was the first state in the nation to restrict the sale of products containing pseudoephedrine. Since the law was enacted, a number of states have followed Oklahoma's lead in restricting pseudoephedrine products. Oklahoma has seen a significant drop—80 percent—in small toxic meth labs as a result of the legislation.

NACo is in support of the Combat Meth Act (S. 103/HR 314) that would replicate the Oklahoma legislation on the national level. By limiting individuals to 7.5 grams (250 pills) of pseudoephedrine per month, the measure would seriously impair the access of meth cooks to obtain this essential component to meth production. The legislation was unanimously adopted in the Senate Judiciary committee and was incorporated into the Senate FY2006 Commerce-Justice-Science appropriations bill. NACo urges members of the House of Representatives to cede to the Senate position and include the Combat Meth Act in the final version of the FY2006 Science-State-Justice-Commerce appropriation bill.

Another option to restrict pseudoephedrine sales is to repeal the federal blister pack exemption. Blister packs are small plastic-and-foil packages that force a consumer to remove cold pills one or two at a time. Currently, federal law allows individuals to purchase an unlimited quantity of pseudoephedrine, as long as the pills are in blister packs. When the blister pack exemption was established, it was believed that the difficulty in accessing these pills would preclude meth cooks from using pseudoephedrine pills. However, it has not proven to be an effective deterrent and meth cooks have exploited this weakness in federal law. NACo supports efforts to repeal the current blister pack exemption, including HR 1350, the Methamphetamine Blister Pack Loophole Elimination Act of 2005.

Additionally, a repeal of the blister pack exemption is contained in the Methamphetamine Epidemic Elimination Act of 2005 (HR 3889). NACo supports this provision in the bill and the provisions that increase international regulation of pseudoephedrine, however NACo respectfully differs with the overall strategy to control domestic sales of pseudoephedrine and increasing mandatory sentencing. Essentially, this legislation lowers the threshold put on retailers to report purchases of pseudoephedrine from 9 grams to 3.6 grams for each transaction. While this may reduce the access that currently exists, NACo believes that the restrictions will fall short in the long-term. Under this provision, meth cooks could go to multiple stores in one day or consecutive days and purchase 3.6 grams (120 pills) of pseudoephedrine. Therefore, NACo believes that the approach laid out in the Combat Meth Act, which has proven successful in several states, represents the most effective attempt to limit access to pseudoephedrine.

Environmental Cleanup

One of the major issues facing communities and property owners is the issue of remediating former clandestine methamphetamine labs. As I noted earlier, the US Drug Enforcement Administration estimates that only 35 percent of all methamphetamine is produced in these small toxic labs. However, these labs pose a significant risk to the community and individuals present at the manufacturing or use of the drug. The labs are highly toxic and the residual contamination from the production of methamphetamine can lead to health risks and threaten the health of children and individuals who may unsuspectingly live in a former lab.

Currently, there are no guidelines for local governments or private landowners to follow for remediating former clandestine meth labs. Additionally, several studies by

Dr. John Martyny at the National Jewish Medical Center have shown that airborne and surface contamination from methamphetamine production or use can be far-reaching. Dr. Martyny found that residual contamination could last for long periods and cause serious health concerns for those individuals and children who are exposed knowingly or unknowingly. NACo supports the bi-partisan Methamphetamine Remediation Act of 2005 (HR 798), which would require the Environmental Protection Agency to establish voluntary guidelines on the clean-up of former meth lab sites. This legislation has passed the House Science Committee and is awaiting action on the House floor.

Drug Endangered Children

Across the nation, alarming rates of children are found present at clandestine meth labs. In 2003, approximately 3,000 children were found during meth lab seizures. In the Western United States, the numbers are more frightening, as Assistant United States Attorney Laura Birkmeyer noted in testimony to the House Government Reform Subcommittee on Criminal Justice and Drug Policy. Birkmeyer stated, that in San Diego, "Drug Endangered Children teams have taken more than 400 children into protective custody in the past 12 months. Significantly, more than 95 percent of these children came from environments where there was methamphetamine use and trafficking but where manufacturing was not occurring. Approximately 1 in 10 of these children tested positive for methamphetamine and of those the children ages 0-6 were twice as likely to test positive for methamphetamine as children aged 7-14."

To better coordinate and respond to the needs of these innocent victims, a Drug Endangered Children pilot program was started in 1997 in California. Drug Endangered Children are those children who suffer physical or psychological harm or neglect resulting from exposure to illegal drugs or to dangerous environments where drugs are being manufactured or chemicals used to make drugs are accessible. These harms may include injury from explosion, fire or exposure to toxic chemicals found at clandestine lab sites; physical abuse; sexual abuse; medical neglect and; lack of basic care including failure to provide meals, sanitary and safe living conditions or schooling.

A Drug Endangered Children (DEC) program is a multi-disciplinary team made up of law enforcement, medical professionals, prosecutors and child welfare workers. Team members are trained to view children found at narcotics crime scenes as crime victims. A typical scenario involves law enforcement breaking up a meth lab and contacting local child welfare officials if a child is present. The child welfare professional assesses the crime scene with law enforcement and determines if the child should be placed in protective custody. An at-risk child would then be given a medical exam, toxicology screen and developmental evaluation. The child would then be placed in a safe foster care environment. The prosecutor would then determine if child endangerment charges are appropriate. This concept bridges the gaps that often exist between these agencies. Furthermore, it represents a comprehensive approach to responding to the health risks of meth posed to children.

NACo supports the bi-partisan Meth-Endangered Children Protection Act of 2005. This legislation would authorize \$10 million annually for the development of Drug Endangered Children rapid response teams. The legislation has been referred to the Health Subcommittee of this committee and we would respectfully ask that this legislation be considered.

Public Health Risks

The National Institute of Drug Abuse notes that methamphetamine users, especially those that inject the drug and share needles, are at increased risk to contract HIV and Hepatitis C. In addition, NIDA reports that methamphetamine can increase the libido in users, which may lead them to practice unsafe sex and lead to transmitting HIV and Hepatitis C. In addition, research and news accounts have shown that this is particularly the case in urban areas with the gay population. To date, NACo has not yet examined the impacts of an increase in these and other sexually transmitted diseases on the county public health system but initial evidence shows that there is a correlation between methamphetamine use and infection.

Prevention/Education

Additionally, NACo believes that education and prevention efforts must be increased to inform children and youth about the dangers of methamphetamine abuse. Many former meth users indicate that they did not know of the ingredients and dangerous consequences of the drug before their first use.

Current funding for the White House Office of National Drug Control Policy's (ONDCP's) National Youth Anti-Drug Media Campaign is set at \$120 million. Out of this funding, \$1 million is targeted for anti-meth educational ads during the cur-

rent year. Reps. Mark Souder (R-IN) and Rick Larsen (D-WA) succeeded in adding \$25 million to the campaign during consideration of the FY2006 Transportation-Treasury-HUD appropriations bill, for a total of \$145 million. The sponsors of the amendment specifically targeted the new funding for anti-meth ads. NACo supports increased funding for the National Youth Anti-Drug Media Campaign targeted at producing and disseminating an anti-meth educational campaign.

Treatment

Despite a pervasive myth that treatment is ineffective for meth users, meth addiction can be treated similar to other forms of substance abuse. Treatment has been proven effective when it is available and the individual is willing to accept it. The Matrix Model, for example, consists of a 16-week intervention that includes intensive group and individual therapy to promote behavioral changes needed to remain off drugs.

According to the National Association of County Behavioral Health and Developmental Disabilities Directors, a NACo affiliate, there are 22 states with county sponsored substance abuse treatment authorities. These states account for 75 percent of the nation's population. The S Btfnl

Research

Iowa State University researchers have developed an additive to anhydrous ammonia that can reduce the production value of meth, while still being a useful fertilizer. The additive is currently undergoing further testing, however if proven successful at limiting methamphetamine production it would be a major break-through for many rural farming communities that have been affected the methamphetamine epidemic.

Law Enforcement

NACo is a strong supporter of the Justice Assistance Grant (JAG) program within the Department of Justice. JAG funding can be used for a variety of purposes including law enforcement, prosecution, prevention, education, drug treatment, planning, corrections and technology improvements. Many counties across the nation use JAG funding for multi-jurisdictional or regional drug taskforces.

Additionally, many counties receive Edward Byrne discretionary funding through congressional earmarks for similar programs. Funding for JAG and Byrne discretionary in FY2005 was \$804 million, however the Bush administration recommended eliminating funding for FY2006. The House of Representatives set funding for JAG at \$478 million. During consideration of the FY2006 Commerce-Justice-Science appropriations bill the Senate added \$275 million to their recommended level of \$802 million to the Justice Assistance Grant for a total of \$1.077 billion. NACo supports the Senate funding level of \$1.077 billion or at least level funding of \$804 million as a minimum for Justice Assistance Grant program funding and urges members of the House of Representatives to cede to the Senate position during conference negotiations.

Conclusion

On behalf of NACo, I would like to thank Chairman Gillmor, Chairman Deal and Ranking Member Solis and Ranking Member Brown for holding this hearing today. Methamphetamine abuse is a scourge on our society that must be addressed in a comprehensive manner by all forms of government. NACo looks forward to working with Congress and the Administration to craft and implement such legislation.

Additionally, NACo is encouraged by the attention that methamphetamine abuse has received recently by the media and policymakers in Congress and the Administration. Newspapers across the country, national magazines and television newscasts have raised awareness of methamphetamine by showing the devastating consequences that meth abuse can bring to families and communities. In Congress, the bi-partisan House Caucus to Fight and Control Methamphetamine has shown leadership in bringing the issue to the forefront. In July 2005, Attorney General Alberto Gonzales stated that, "in terms of damage to children and to our society, meth is now the most dangerous drug in America—a problem that has surpassed marijuana."

Lastly, NACo will be conducting several additional surveys on other aspects of the methamphetamine epidemic. As I mentioned earlier, the next round of surveys will be on the impacts to the treatment delivery system and public health system. We would welcome the opportunity to come before this committee and present our findings at the appropriate time. Again, we thank the Chairmen, the Ranking Members and members of the subcommittees for the opportunity to submit testimony on the methamphetamine crisis facing this nation.

Mr. GILLMOR. Thank you very much, Commissioner. Mary Ann Wagner, the National Association of Chain Drug Stores.

STATEMENT OF MARY ANN WAGNER

Ms. WAGNER. Thank you, Chairman Gillmor, Chairman Deal, Ranking Member Brown, Ranking Member Solis, and other distinguished members of the Energy and Commerce Subcommittees on Health and Environment and Hazardous Materials. We certainly appreciate the opportunity to be here today and the opportunity to view our concerns to you regarding Federal legislation in the methamphetamine problem.

The National Association of Chain Drug Stores, or NACDS, represents over 200 chain drug companies. The diversity of our membership includes traditional chain drug stores, supermarket pharmacies, and mass merchants. We operate—our membership operates over 35,000 pharmacies, employs 108,000 pharmacists, and fills over 2.3 billion prescriptions a year.

NACDS and our member companies have been very involved with the methamphetamine problem for 10 years now, since 1995. A number of members have done voluntary programs within their stores and have taken a number of measures voluntarily, including sales limits that they imposed upon their stores sometimes as many as 7 or 8 years ago, training for their employees, signage in their stores. Some of them have removed products voluntarily and put it behind the counters when there was evidence of theft or shop sweeping.

They have been involved with Meth Watch programs in their communities, working hand-in-hand with law enforcement to report suspicious activity within their stores. In the past year, a number of them have voluntarily taken products off their shelves and put them behind the counter. Some of them have even removed products from their stores that don't contain pharmacies. Two of our member companies have implemented electronic tracking programs.

And we have been involved, of course, with Federal legislation this past year, both on the Senate side and on the House side. We have had a number of calls, conference calls and meetings on methamphetamine. Our members are extremely engaged in this and want to do what they can to help law enforcement. We do have a great deal of empathy for what the local law enforcement officials are going through in cleaning up these labs and the fact that it is draining their resources, both financially and human resources. So we do want to help and work with them to do what we can.

There is a very delicate balance that we have been sure to try to follow through, and that is keeping the product available for legitimate customers who have legitimate needs for cough and cold products, as well as restricting access to those who might illicitly manufacture meth.

We support a stringent comprehensive and standardized approach to solving the methamphetamine problem. Specifically, we believe that the Federal Government should play a vital role in helping to address the growing problem of methamphetamine production and addiction.

In addition to addressing enforcement, education, treatment, and cleanup issues, we strongly believe that any comprehensive approach should include a national standard for limiting consumer access to products that can be used to manufacture methamphetamine.

One national standard for retail availability is important because the current patchwork of more than three dozen different State requirements in addition to scores of local ordinances in cities, towns, and counties throughout the country is confusing to consumers and to law enforcement.

The key to a national standard would be to preempt only retail requirements for pseudoephedrine sales in State laws. And by that I mean we wouldn't want to touch the law enforcement provisions that States may choose to enact, but definitely on retailer requirements.

We do not believe it is necessary for consumers to have to obtain a prescription in order to purchase pseudoephedrine products. This is why we support keeping the sale of pseudoephedrine products available without a prescription. We support maintaining a written or electronic log of pseudoephedrine purchases to assist law enforcement efforts. We support limiting retail and distribution reporting, record keeping, storage, and dispensing requirements. We support funding for law enforcement as far as education, prevention, treatment, cleanup, and all of those items as well.

So in conclusion, NACDS is committed to work with the Committee and other Federal policymakers, the Administration, local law enforcement to find a comprehensive solution to this problem. Thank you.

[The prepared statement of Mary Ann Wagner follows:]

PREPARED STATEMENT OF NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NACDS appreciates the opportunity to testify before the House Subcommittees on Health and Environment and Hazardous Materials to address the methamphetamine problem.

The National Association of Chain Drug Stores (NACDS) represents the nation's leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. NACDS members operate more than 35,000 pharmacies, employ 108,000 pharmacists, fill more than 2.3 billion prescriptions yearly, and have annual sales of over \$700 billion. Other members include almost 1000 suppliers of products and services to the chain drug industry. NACDS international membership has grown to include 90 members from 30 countries. For more information about NACDS, visit www.nacds.org.

Our membership is deeply concerned about the problems of methamphetamine production and abuse. NACDS continues to have ongoing calls and meetings to discuss this issue and to develop solutions to this devastating problem in our country. The majority of the chain community pharmacy industry has taken voluntary, proactive steps that go beyond what is required by law to reduce the theft and illegitimate use of pseudoephedrine products. They:

- have placed these products behind pharmacy and/or sales counters voluntarily, or have otherwise limited access to these products in their stores,
- have initiated voluntary sales limits of these products,
- participate in voluntary education and theft-deterrent programs such as Meth Watch,
- voluntarily eliminate consumer self-access to pseudoephedrine products in their stores in geographic areas where methamphetamine is a problem,
- participate in youth anti-methamphetamine education efforts,
- educate their employees about methamphetamine abuse to raise awareness and prevent questionable sales of these products, and
- work with law enforcement by reporting suspicious activity in their stores.

Moreover, chain pharmacy has worked closely with the Drug Enforcement Administration (DEA) and state and local law enforcement officials since 1995 to stem the tide of methamphetamine production in communities across the U.S.

INTRODUCTION

Almost one year ago, on November 18, 2004, NACDS testified before the House Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources about law enforcement and the fight against methamphetamine. At that time, NACDS commented on various solutions we believe would help reduce the methamphetamine problem. These solutions include:

- Encourage states to pass necessary restrictions and penalties upon those arrested for and/or convicted of methamphetamine-related offenses;
- Federalize methamphetamine-related offenses;
- License non-pharmacy retailers that sell pseudoephedrine products;
- Significantly increase funding for methamphetamine abuse prevention programs;
- Work in concert with the State Department and officials in chemical producing countries (e.g., India, China, the Czech Republic and Germany) to more closely track every sale of pseudoephedrine into the United States;
- Provide incentives for drug companies to develop an effective decongestant that cannot be converted into methamphetamine;
- Provide more funding and resources to DEA for enforcement activities;
- Enact import controls on bulk pseudoephedrine and ephedrine similar to Schedule II controlled substances; and limiting imports to those necessary for legitimate commercial needs;
- Provide funding resources to local law enforcement for methamphetamine lab cleanup;
- Provide additional funding for treatment of methamphetamine addicts so that they can eventually become productive members of our communities; and
- Continue to coordinate with Canada and Mexico on distribution tracking and control of pseudoephedrine and ephedrine.

METH EPIDEMIC ELIMINATION ACT

We are pleased that both the U.S. House of Representatives and Senate have introduced legislation that reflects solutions identified by NACDS. We applaud Representatives Mark Souder (R-IN) and Jim Sensenbrenner (R-WI) for their leadership in introducing the Meth Epidemic Elimination Act (H.R. 3889) to address the methamphetamine problem. Many of the provisions in the Meth Epidemic Elimination Act are similar to provisions that we have advocated, including the recommendations we provided in our testimony on November 18, 2004. We advocated for import and export controls for pseudoephedrine, and this is exactly what has been proposed by Sections 102, 103, 104, 105, 106, 201 and 202. DEA admits that there exists a very large discrepancy between U.S. bulk pseudoephedrine import records and the records of legitimate U.S. manufacturers of pseudoephedrine-based products. No one is sure where the unaccounted bulk pseudoephedrine goes—most likely into criminal hands. We believe that import and export controls are necessary to reduce diversion of bulk pseudoephedrine.

We have advocated for enhanced penalties for methamphetamine related offenses. This has been proposed under Title III of the Meth Epidemic Elimination Act. We have advocated for funding for methamphetamine lab cleanup costs. This has been addressed in Title IV of the Meth Epidemic Elimination Act. We believe these provisions will assist local law enforcement officials as they struggle to handle the methamphetamine problem throughout the country. Local law enforcement officials in communities all across the country have indicated that their most severe problem continues to be with the small methamphetamine labs, which are draining all their time and resources. Once we help them resolve the problems associated with methamphetamine production by the small labs, they can better prepare themselves to focus on the larger problem of methamphetamine abuse.

COMBAT METH ACT

The Combat Meth Act, introduced by Senators Jim Talent (R-MO) and Dianne Feinstein (D-CA), would provide numerous tools to law enforcement and includes numerous provisions that would provide treatment and education resources. For example, the Combat Meth Act would:

- expand the Methamphetamine Hot Spots Program to include personnel for enforcement, prosecution, and cleanup;

- provide funding for the Attorney General for training and cross-designating of local prosecutors as Assistant Attorneys General;
- provide grant funding for Drug Endangered Children rapid response teams to assist children that have been affected by the production of methamphetamine;
- authorize the creation of Methamphetamine Research, Training and Technical Assistance Centers to research effective treatments for methamphetamine abuse and disseminate information and technical assistance to states and private entities on how to improve current treatment methods; and,
- Provide local grants for treatment of methamphetamine abuse and related conditions.

We commend Senators Talent and Feinstein for their leadership in pursuing a role for the federal government to assist with stopping methamphetamine production and addiction. We support these provisions because we believe that these provisions would address the problems of both methamphetamine production and abuse through a comprehensive approach.

The Combat Meth Act provides a comprehensive solution by giving local law enforcement the necessary tools and resources to pursue methamphetamine offenders, and state prosecutors the power to effectively prosecute methamphetamine cases. NACDS has encouraged states to impose necessary restrictions and penalties upon those arrested for and/or convicted of methamphetamine-related offenses. We are pleased that the federal government is assisting states in these matters.

The Combat Meth Act also provides critical funding for methamphetamine education, training, research, treatment, and child endangerment programs. The Combat Meth Act's comprehensive approach seeks to reduce methamphetamine demand by educating consumers about the life-threatening dangers of methamphetamine abuse and by providing treatment to free methamphetamine addicts from their addiction.

A NATIONAL STANDARD AS PART OF A COMPREHENSIVE APPROACH

Just as we believe that a comprehensive approach is necessary to combat the methamphetamine problem, we believe that a comprehensive approach should include a national standard for limiting consumer access to products that can be used to manufacture methamphetamine. One national standard for retail availability is important because the current patchwork of more than three dozen different state requirements, in addition to scores of local ordinances in cities, towns, and counties throughout the country, is confusing to consumers and law enforcement. For chain pharmacies, which operate in practically every state, city, town, and county in the country, it is complex and costly to have to create different policies, procedures, and employee training programs for every different pharmacy outlet. A national standard for retail availability will streamline our members' operations and allow for better and quicker compliance nationwide. With respect to the Combat Meth Act, we have supported the following principles for selling products containing pseudoephedrine:

- Preempting retailer requirements in state laws;
- Keeping the sale of pseudoephedrine products available without a prescription;
- Requiring sales of single entity products from behind the pharmacy counter and sold by a licensed pharmacist or pharmacy personnel;
- Requiring sales of combination products from behind the pharmacy counter by January 1, 2007 and sold by a licensed pharmacist or pharmacy personnel;
- Maintaining a written or electronic log of pseudoephedrine purchases to assist law enforcement efforts;
- Limiting purchases to 9 grams within a 30-day period; and,
- Limiting distribution center storage requirements.

Key to a national standard is the preemption of state laws. A national standard could exist only if states are preempted from imposing different requirements upon retailers.

Many of the principles we have supported closely mirror the provisions of the Combat Meth Act. However, the Combat Meth Act would designate pseudoephedrine products as Schedule V controlled substances. We did not include "Schedule V" in our principles because we have concerns about such a designation. These concerns include the fact that in nineteen states, pseudoephedrine products could be sold only upon the order of a prescribing practitioner if they were designated a Schedule V product. We do not believe that a consumer should have to visit a practitioner to obtain a prescription in order to purchase pseudoephedrine products.

Moreover, designating pseudoephedrine as a Schedule V controlled substance would impose undue burdens upon pharmacies. For example, DEA prescribes certain forms, procedures and recordkeeping requirements for controlled substances

that would be extended to pseudoephedrine if pseudoephedrine were designated a Schedule V controlled substance. Pseudoephedrine products would have to be stored in a locked cabinet or dispersed throughout the pharmacy. These products could only be ordered from wholesalers by pharmacists. Specific forms and procedures would have to be used for the destruction of such products. Additionally, for a theft or loss of pseudoephedrine, specific forms and procedures would have to be used. Pseudoephedrine invoices would have to be signed and dated and saved separate from other invoices. Dispensing records would have to be maintained separately from other dispensing records and pharmacists would have to review the dispensing records on a daily basis and sign and date the dispensing records on a daily basis. Finally, a detailed inventory of all pseudoephedrine products would have to be performed on a biennial basis. We believe that the goal of federal legislation is to limit access, and not place recordkeeping, storage, and other procedural burdens on pharmacies. We believe that the goal of limiting access can be achieved without designating pseudoephedrine as a controlled substance.

TRANSIENT VENDORS

In addition to limiting access to pseudoephedrine products by traditional retailers and pharmacies, we believe that a comprehensive federal solution should address the problem of pseudoephedrine sales by transient or limited vendors, such as at flea markets. Many of the products sold at flea markets were originally acquired from questionable sources, often they were stolen from legitimate retailers. As such, we would support legislation that would address all retail theft, including the theft of pseudoephedrine products. We believe that such legislation should prohibit the sales of nonprescription products, as defined in the Federal Food, Drug, and Cosmetic Act and regulations issued under that Act, and infant formula manufactured and packaged for sale for consumption by children under 2 years of age, by a transient or limited vendor, unless the vendor maintains for public inspection written documentation including invoices and other appropriate business records identifying the vendor as an authorized representative of the manufacturer or distributor of that product.

CONCLUSION

A comprehensive approach is necessary to effectively address the methamphetamine problem. A comprehensive approach includes reducing demand for methamphetamine. Experience with the drug abuse problem has shown that these problems are not eliminated by merely erecting barriers to the drug supply, but we also must focus resources on drug abuse prevention and treatment; we must eliminate the demand for drugs. So long as people are addicted to drugs, they will find ways to get them.

We believe that both the U.S. Senate and House of Representatives have introduced legislation that represents comprehensive approaches to address the methamphetamine problem. Both the Meth Epidemic Elimination Act and the Combat Meth Act will further assist law enforcement by providing more funding and resources for methamphetamine abuse prevention, treatment, and cleanup. These provisions should reduce the demand for methamphetamine, which will have long-lasting benefits.

Mr. GILLMOR. Thank you very much. Gordon Knapp of Pfizer?

STATEMENT OF GORDON KNAPP

Mr. KNAPP. Yes. Thank you, Mr. Chairman, and good afternoon. And thank you for this opportunity to testify before your combined subcommittees and for your attention to this crucial issue of methamphetamine abuse in America.

Of the manufacturer of Sudafed, the largest pseudoephedrine based brand in the U.S., Pfizer has long been involved in the fight against meth abuse. We have supported Federal and State sales limits and packaging guidelines for PSE. We have funded Meth Watch programs in over a dozen affected States. And this year we introduced the first major PSE-free cold medicine, Sudafed PE, to American consumers.

Over time, despite the valiant efforts of law enforcement, we have seen America's meth crisis continue to deepen. We at Pfizer have concluded that tough comprehensive action, including Federal legislation to place all PSE products behind the counter, is necessary to combat this meth abuse and the proliferation of small toxic meth labs.

We view the different bills now under consideration by the House, with some modifications, as being fully compatible and complimentary approaches to addressing this multi-faceted problem.

My submitted testimony focuses on the principals that we believe should guide the legislation. I will speak briefly to three of those now. First, PSE needs to go behind the counter, whether a pharmacy counter or perhaps other secure locations. States that have done so have seen a sharp drop in small toxic labs. Many who were initially skeptical of those laws, and to be fair, that included many of us in the industry, now accept that putting PSE behind the counter is an effective part of a comprehensive anti-meth strategy.

Second, Pfizer believes that designating PSE a Schedule V controlled substance is the wrong way to move PSE behind the counter. Schedule V has unintended side effects that would burden consumers, medical practitioners, the industry, and do little to keep PSE out of the hands of criminals.

Schedule V can trigger by prescription only provisions in up to 19 States, which would make it necessary for consumers to bear the added time and expense of seeing or contacting a doctor, paying an Rx dispensing fee. Prescription medicines containing PSE, like Pfizer's own Zyrtec D also would be caught up in the nationwide Schedule V net. In some States, this would mean that mid-level medical practitioners, such as qualified RN's, could no longer prescribe these medicines and doctors could no longer sample them.

By moving PSE behind the counter nationally, Congress can have the same impact on small toxic labs as Schedule V without these unintended side effects. If Congress nonetheless decides to designate PSE a Schedule V controlled substance, these side effects of the law could and should be dealt with by amendment.

Finally, with PSE moved behind the counter nationally, Pfizer believes the entire category should be included, for the simple reason that our formulations of PSE can be converted into meth. Pfizer sells liquids and liquid-filled capsules or cells. If we believe that these or any other form of PSE resisted conversion into methamphetamine, we would ask you to exempt it, but we know different.

We have tested these products, State criminal labs have tested them, and the DEA has tested them, all with the same result. They can be readily converted using common street methods. The ONDCP reports that word is out on the street in Oregon and that liquids and gel caps can be converted into meth, and both have now been found in local labs there. Unlike State laws that exempt these products, as some do, a Federal exemption would create a perverse incentive for the entire industry to reformulate the products that we know can be made into meth.

Last January, Pfizer introduced our first PE product, Sudafed PE. We did so after investing years and millions of dollars trying to develop a form of PSE, which we called Lock II, that could not

be converted to meth. We have continued to reformulate the PE products and our competitors have quickly followed suit. An implementation date of January 2007 would give other companies time to catch up and retailers the time they need to prepare.

It is clear that the U.S. is moving toward a new paradigm in the cold and sinus category, PSE behind the counter and PS-Free in front of the counter. By 2007, we expect that up to 75 percent of our cold and sinus sales will be PE products.

At latest count, more than 30 States have passed some form of PSE restrictions, creating a patchwork quilt of legislation. Ideally, Federal legislation will preempt State laws, leaving a predictable legislative environment that allows retailers, manufacturers, and consumers to plan and engage in commerce without undue burden.

Mr. Chairman and members of the subcommittees, strong bipartisan coalitions in the House and Senate have endorsed tough action to fight meth abuse. Law enforcement, the drug control community and industry stand behind you. We at Pfizer are pledged to do all that we can to assist your efforts. We look forward to working with you and to answering your questions. Thank you.

[The prepared statement of Gordon Knapp follows:]

PREPARED STATEMENT OF GORDON KNAPP, PRESIDENT, NORTH AMERICA REGION,
PFIZER CONSUMER HEALTHCARE

Good morning. Thank you for this opportunity to testify before your combined subcommittees, and for your attention to the crucial issue of methamphetamine abuse in America.

As the manufacturer of Sudafed, the largest pseudoephedrine (PSE) brand in the U.S., Pfizer has long been involved in the fight against meth abuse. In the 1990s, we supported federal sales regulation and packaging guidelines for PSE. In 2002, we were the first in our industry to support even tougher state-level limits on the amount of PSE that consumers could purchase per sale. We have funded and been engaged in developing "meth watch" programs in over a dozen affected states. And this year, we introduced the first major PSE-free cold medicine—Sudafed PE—to American consumers.

Over time, despite the valiant efforts of law enforcement, the work of manufacturers and retailers, and the efforts of state legislators, we have seen America's meth crisis continue to deepen. In the face of this challenge, we at Pfizer have concluded that comprehensive action, including federal legislation to place all PSE products behind-the-counter, is a necessary part of any comprehensive strategy to combat meth abuse and the proliferation of small toxic meth labs.

Setting aside the details of implementation for a moment, we seem to be approaching a national consensus on how best to address America's methamphetamine problem. Taken together, bipartisan bills introduced in the House and the Senate point to the need for a comprehensive approach that will restrict access to PSE at the point of sale, control the importation of PSE into the United States, and adequately fund law enforcement, treatment, and education efforts. Pfizer supports all these approaches. We view the different bills now under consideration by the House, with some modifications, as fully compatible and complementary approaches to addressing the multi-faceted problem of meth abuse.

Pfizer has long taken the position that we need to strike the right balance between making medicines available to legitimate consumers and restricting access to criminals who would use our medicines for illicit purposes. Today, I would like to focus my comments on the principles that we believe should guide legislation, particularly regarding limits on the sale of PSE to consumers:

- Establish a single national standard restricting PSE sales to "behind the counter" in pharmacies, and perhaps certain other retailers;
- Oppose the classification of PSE as a Schedule V controlled substance;
- Regulate all forms of PSE equally—including solid-ingredient tablets, combination products, liquid gel caps and liquids—since the DEA confirms that all can and are being used by criminals to make meth;
- Impose national gram or package limits on the amount of PSE that can be purchased by an individual;

- Allow for a phase-in period, until January 2007, to give retailers adequate time to adjust to new restrictions;
- Fully fund anti-meth enforcement, education and treatment programs, including tough criminal statutes and import controls;
- Pre-empt divergent state and local laws and apply a single national standard.

Behind the counter...but not Schedule V

Theft of PSE from store shelves has been a source of supply for criminals. Where PSE has moved behind the counter, criminals have found it much tougher to get their hands on it, and local meth lab busts have dropped. Many who initially were skeptical of these laws, and to be fair that included many of us in industry, now accept that putting PSE behind the counter is an effective part of a comprehensive anti-meth strategy.

Pfizer believes that Congress should mandate that PSE be sold from “behind the counter,” either the pharmacy counter or more broadly, but that designating PSE a Schedule V controlled substance is the wrong way to achieve this end. The reason is that Schedule V has unintended side effects that would impose unnecessary restrictions on consumers, medical practitioners, and industry, while doing little or nothing to keep PSE out of the hands of determined criminals.

For example, Schedule V can trigger “by prescription only” provisions in up to 19 states, which would make it necessary for consumers to visit or contact a doctor every time they feel a cold coming on and want to buy a medicine containing the decongestant they have relied on for years. The added inconvenience and expense of requiring a prescription for PSE is unreasonable in an environment in which PSE already is behind the counter. The same can be said of security and storage requirements that pertain to Schedule V drugs only.

Another unintended side effect of “Schedule V” is that *prescription medicines* containing PSE as an active ingredient (such as the “D” formulations of Rx allergy medicines) would be caught up in the nationwide Schedule V net. In some states, this would mean that mid-level medical practitioners, such as qualified RNs, could no longer prescribe these medicines, and doctors could no longer give them as samples to patients. Since, by definition, prescription medicines already can be dispensed only by a licensed pharmacist, the additional burdens of imposing Schedule V restrictions on Rx medicines are entirely unnecessary.

Moreover, under Schedule V, PSE sales would be limited to behind the pharmacy counter only. If Congress decides to allow sales somewhat more broadly, Schedule V does not offer that flexibility.

If, however, Congress nonetheless decides to designate PSE a Schedule V controlled substance, provision should be made in the legislation to limit the unintended side effects of the law by: (1) *exempting Rx products*, (2) *including clarifying language that avoids triggering state “Rx only” statutes for Schedule V drugs*, and (3) *exempting PSE from Schedule V security and storage requirements*.

Regulate the entire category equally

If Congress decides to put PSE products behind the counter, as we believe you should, then the entire category should be included for the simple reason that all formulations of PSE now on the market can be converted into meth. The only possible exception might be certain pediatric products that simply do not contain enough PSE to make theft worthwhile.

Pfizer manufactures or sells all forms of pseudoephedrine: single ingredient tablets, combination ingredient tablets, liquid-filled capsules, and liquids. If we believed that any one of these were particularly resistant to conversion into methamphetamine, we would request that you exempt it. Unfortunately, we know differently.

The June issue of the DEA *Microgram Bulletin* reports the results of two studies, one by the Washington State Patrol Crime Laboratory, and one by an independent forensic laboratory on behalf of McNeil Consumer and Specialty Pharmaceuticals. Both studies produced methamphetamine from liquid filled capsules and liquids using approaches similar to small toxic labs. These findings accord with a study prepared by another outside laboratory for Pfizer, which extracted PSE from liquid-filled capsules and liquids using a recipe found in a book available through a popular on-line store. A study by the DEA’s North Central Regional Laboratory in Chicago had a similar result.

According to the Office of National Drug Control Policy, word already is out “on the street” in Oregon that liquids and gel caps can be converted into meth, and both have now been found in local labs. Criminals will use the products and methods they are familiar with, and switch to others if those no longer are available.

It is true that most—though not all—states have exempted liquids and gel caps from their anti-meth legislation. Were Congress to do so, however, there would be

wide ranging consequences. A national exemption for liquids and gel caps would create an incentive for the entire industry to switch its manufacturing to those products—products that we know can be made relatively easily into meth. Inevitably, criminals everywhere would catch on, and we all would have wasted even more time in getting a handle on the problem of local toxic meth labs.

If, however, Congress includes all forms of PSE in legislation, you instead will create incentives for companies to develop and switch to non-PSE alternatives, an effort in which Pfizer has been engaged for many years. An implementation date of January 2007 would give these companies and retailers the time they need to prepare.

The search for solutions

Mr. Chairman, I have a story to share that we rarely have discussed publicly, the story of our ultimately unsuccessful efforts to develop a form of PSE that could not be converted into meth. What we called “Lock II” technology was an attempt to bind PSE with other chemicals that would prevent extraction and conversion. Over a period of years and an investment of millions of dollars, we developed a product that we believed could not be converted by local labs into methamphetamine. To be sure of what we had, we asked the DEA to give it their best shot to break the formula using street methods. What they told us came as a surprise: Lock II *could* be broken using a chemical increasingly employed by local meth cooks. While our Lock II technology would have been tough to crack (many times harder than liquids or gel caps), it was vulnerable. We understood that to switch our own line—and potentially an entire industry—to the new technology would succeed only in pushing the problem down the road. We were and are interested in permanent solutions.

As it became clear that the technical solutions we developed were impractical, Pfizer set about pursuing another plan. We decided to replace, and in some cases supplement, our PSE containing medicines with a new line of products containing phenylephrine (PE) as the decongestant ingredient. While PE is FDA approved, American consumers had limited exposure to it. To get a better idea of acceptability, we ran consumer tests in the U.S. that showed no statistical difference between PSE and PE in terms of consumers’ perceptions of symptom relief.

Last January, we introduced our first PE product, Sudafed PE. We have since switched other Sudafed, Actifed and Benadryl products from PSE to PE, and by early next year we expect to have most of our brand lines switched over. As we hoped and expected, we have started a trend. Private label (store brands) quickly followed our lead. And we are pleased to see that one of our major competitors has just replaced its popular day and night cold medicines with “pseudoephedrine-free” formulas, one of which contains PE. We understand that another competitor may be about to follow suit.

Even without legislation, a number of major retailers including Wal-Mart and Target have voluntarily moved some or all PSE behind the counter. It is clear that *the U.S. is moving toward a new paradigm in the cold and sinus category: PSE behind the counter, “PSE-free” in front of the counter.* The argument that moving PSE behind the counter will unduly restrict access to cold medicines may have been true two years ago. It is no longer true today, and will be less so moving forward. The fact is, between the efforts of Pfizer and our competitors, and America’s forward-thinking retailers, consumers soon will have a plethora of “PSE-free” medicines available on the store shelf. For those who still prefer PSE, as some consumers undoubtedly will, all they will have to do is ask for help in getting the medicine they need.

Why federal action makes sense

At latest count, more than thirty states have passed some form of PSE restrictions, and over half the remaining states have legislation pending. Restrictions range from Schedule V, which is interpreted differently in different states, to gram or package limits, to menus of options for display and sale of PSE containing medicines. This patchwork quilt of state regulations is precisely why federal legislation is necessary. Ideally, federal legislation will pre-empt state laws, leaving a predictable legislative environment that allows retailers, manufacturers, and consumers to plan and engage in commerce without undue burden. Legislation in the absence of preemption might have the salutary effect of dampening down legislative activity in the states for awhile, but it would leave in place many divergent laws, and the prospect of more changes to come. It would be preferable, from our point of view, to solve the problem once.

The opportunity before us

There are a number of other issues that undoubtedly will be addressed today by my fellow panel members. How many grams or packages of PSE should be allowed

per sale or per month? Should non-pharmacies be allowed to carry PSE products behind the counter, and what specific security arrangements might be needed? Should single-dose packets be sold in airports and other transit locations? These are all important issues, and I will be happy to comment on them during questioning.

Whatever differences may exist over details, however, we should not lose sight of the fact that a historic opportunity is at hand. Strong bi-partisan coalitions in the House and Senate have endorsed action. Law enforcement, the drug control community and industry stand behind you. We at Pfizer are pledged to do all we can to assist your efforts to take meaningful, comprehensive action to fight meth abuse. We look forward to working with you and to answering your questions.

Mr. GILLMOR. Thank you very much. And we will now go to Sheriff Ted. And I hope I pronounce this right, Ted. Is it Kamatchus?

Mr. KAMATCHUS. It is Kamatchus, sir.

Mr. GILLMOR. Very good. Representing the National Sheriffs' Association.

STATEMENT OF TED G. KAMATCHUS

Mr. KAMATCHUS. Mr. Chairman and members of the Committee, my name is Ted Kamatchus and I am the sheriff of Marshall County, Iowa. I would like to thank the members of this distinguished panel for inviting me to Washington and allowing me to share my experience with you regarding the national methamphetamine problem.

I am a 29-year veteran of law enforcement and I am in my eighteenth year as serving my county as its sheriff. I currently serve as the First Vice President of the National Sheriffs' Association. You will find my professional bio in your packets.

On March 24, 1999, I was honored to speak before a Congressional subcommittee on methamphetamine use. My message then was much the same as the one I bring to you today. In 1999, the Midwestern States were experiencing a rapid rise in the use of methamphetamine. Officers were finding labs popping up all across the Heartland.

At that time, the flow of meth from its traditional suppliers in Mexico was being attacked by law enforcement. Larger seizures were common. And eventually, two of the four main meth supplying drug cartels were severely damaged. To feed the need for methamphetamine, the users discovered a process of manufacturing the drug that was easy and gave them accessibility to a product that was often times stronger than they could find from across the border.

Meth has no stereotypical user. From the rich and famous to the runaway on the street, once it grabs you, few people become successful at breaking away from the clutches of its addiction.

In 1994, law enforcement, excuse me, officers in Iowa found two meth labs. At the end of 2004, just 10 years later, 1,472 labs were seized and destroyed in the State. When considering major impact issues that come before Congress on a daily basis, I would imagine that few statistical indicators have ever shown such an alarming increase.

What does this mean? What is the true impact on our society? The physical impact on America is devastating. Last year, nearly \$3 million was spent in Iowa for lab disposal and cleanup. During that same period, an Oklahoma Department of Public Safety study attributed an expense of \$350,000 for each lab that was in exist-

ence. This amount was determined by the study, having considered all of the various social economic factors that were touched by meth addiction. Multiply that amount by the 1,100-plus labs in Oklahoma or the 1,400-plus labs in the State of Iowa, and you can see the burden carried by the American taxpayer.

The State of Iowa saw this and we enacted a very strict pseudoephedrine law. It should be noted that since this law took effect in April of 2005, we have found a 78 percent reduction in meth labs in our State. And this problem no longer is just a Midwestern issue.

Methamphetamine is flowing across America. The increase of the drug's availability is enhanced by its ease of manufacturing and inexpensive cost. Once this poison begins to expand into the major metropolitan areas, the cost to the American public will devastate our economy.

Like you, I am elected by the public. Ninety-eight percent of the over 3,000 sheriffs in this country are elected. And the Office of Sheriff possesses a unique view of the total impact that drug addiction has on our society. We are the only full lined law enforcement entity in our country.

Like our brothers and sisters in police agencies, the majority of the Sheriffs' Offices also perform full criminal investigative enforcement. But as sheriffs, we also are active in the civil and court aspects of law enforcement. We serve civil process, committals, and forfeitures. I myself personally have seized homes, vehicles, and children from families as a direct result of the court action brought upon them due to their drug abuse.

And the sheriffs operate the jails in this country. No individual is accepted into the prison system without first having gone through jail at some time in this process. Due to the toxicity of meth, we find that users need far more medical treatment. Kidney dialysis and anti-psychotic medications are the norm for the meth addicts that we incarcerate.

Ladies and gentlemen of this committee, I come before you today to ask your support and assistance. With all the trying times facing this nation, we can ill-afford to open the door to more catastrophic and disruption. While our enemies are at our gate knocking on the door and waiting for us to weaken, we cannot allow our nation to destroy itself.

This is more than a group of weak individuals using the substance for self pleasure. It is a major part of our society that is destroying itself and the country's future. I ask that you give full consideration to supporting efforts currently being submitted to Congress to fully fund the fight against drugs in America, to take on the war on drugs that so many of your colleagues and yourselves have mentioned in years past.

Legislation is needed to secure pseudoephedrine from over purchase potential and shoplifting cooks. We must not turn our back to those individuals who have dedicated their lives to protecting and serving. To cut funding from the JAG/Byrne or HIDTA programs will eliminate drug taskforces in 38 of the 50 States in this country. I shudder to think of the ramifications of that occurring with inadequate monitoring and enforcement.

I want to thank you again for this opportunity to come before you today. I have great faith in our system of government and know that through your hard efforts our country will have a stronger and more resilient future. I want to thank you very much for this opportunity.

[The prepared statement of Ted G. Kamatchus follows:]

PREPARED STATEMENT OF TED G. KAMATCHUS, SHERIFF, MARSHALL COUNTY, IOWA

Mr. Chairman and Members of the Committee: My name is Ted Kamatchus and I am the Sheriff of Marshall County, Iowa. I would like to thank the members of this distinguished panel for inviting me to Washington and allowing me to share my experience with you regarding the National Methamphetamine problem. I am a 29-year veteran of law enforcement and am in my 18th year serving my county as its sheriff. I currently serve as the 1st Vice-President of the National Sheriffs' Association. You will find my professional bio in your packets.

If you would indulge me, I would like to read briefly from the testimony I presented to Congress in 1999.

"Make no mistake about it. We are facing one of the worst drug problems America has ever confronted. In the 1980's, the drug of choice was cocaine. In the early 1990's, we faced a heroin epidemic and now at the close of the century with the dawn of a new millennium, we confront efforts to legalize marijuana as we face an international invasion of methamphetamine.

Meth (or crank) is one of the greatest challenges we face as law enforcement officers. Meth labs are highly toxic, environmental disasters. The chemicals used in the production of crank are volatile and enforcement activity at a lab must be handled with extreme caution. One wrong move could touch off an explosion. As sheriff, a locally elected law enforcement official, I have a unique perspective on this new epidemic. I have been to meth labs. I have been on drug raids and I have purchased crank by the pound in undercover operations. I have seen first hand how this highly addictive drug destroys our kids and I have had to visit too many homes to try and explain to parents that their teenager just died of an overdose. We must do something to stem the tide of illegal drugs, especially meth."

That is how I began testimony before a similar committee in Congress on March 24, 1999. Just prior to that testimony, my community had received national attention through an article published in U.S. News and World Report magazine. The article had discussed the trafficking of Methamphetamine into the heartland of America and how Marshall County was the epicenter of that process. The writer had actually infiltrated Mexican Drug Cartels and found direct links of two cartels to our area.

As a result of efforts by the National Sheriffs' Association and other national law enforcement associations, we were able to convince the Congress of the United States to maximize funding for our efforts in fighting drugs in America. Emphasis was placed on the infiltration of Methamphetamine from abroad. As a result, huge seizures of product occurred and 2 of the 4 primary drug cartels involved sustained major set-backs. These setbacks greatly decreased the availability of Methamphetamine to the users in our area.

There is no a-typical user of Meth in our country. From the rich and famous to individuals on the street, all have seemed to find a purpose in selecting Meth as their drug of choice. As major suppliers were slowed or eliminated, addicted users turned to other means of supplying their habits. It was these addicts who were driven to find fuel for their addictions by developing small local "user" labs for the product. The majority of these labs utilized the Nazi "cold cook" method of manufacturing the drug. Primarily using the internet as a reference book, home grown "chemists" or "cooks" began sprouting up throughout the country.

You will note in your packets the growth of labs in the State of Iowa. The total number of Meth labs seized during the year 1994 was 2. The total number of labs seized in 2004 was 1,472. When considering issues of major impact brought before the Congress, I would imagine that few statistical indicators have ever jumped at such an alarming pace.

But what does this mean? What is the true impact on our society? Over the past 10 years, I have grown to learn more about this issue than I would have ever cared to learn. Let me take a few moments to discuss with you some figures compiled by the Iowa Office of Drug Control Policy. Please understand this is an issue that is rapidly spreading across our country. *It no longer resides solely in the Midwest!* The fingers of its use and abuse are seen reaching throughout the East coast. As I read you the numbers we have found in Iowa, you only have to pause a moment to con-

sider the huge long term economic and environmental impact it will have on the rest of our country.

What is Meth?

Although I am sure you have a better understanding than the average citizen, I want to do all I can to give a complete overview of Methamphetamine so that anyone who may monitor or read this testimony will possess as complete an understanding of the problem as possible.

Meth is made with common chemicals such as; ether; sodium hydroxide (lye); drain cleaner; lithium (from Batteries); red phosphorus (from matchbooks and flares); camping fuel; and pseudoephedrine. While there are many different recipes for making methamphetamine all mixtures include *one common and essential ingredient: pseudoephedrine*. If you aren't aware of pseudoephedrine, it also is one of the primary ingredients in cold, sinus and allergy medications. The molecular structure of it is only 1 step away from methamphetamine. The mixture of the aforementioned precursors causes the transformation of that structure into the poison we call Meth.

But it is more than the drug itself that is of concern. The remaining byproducts from the process of "cooking" meth are equally as dangerous. The impact this refuse has on the environment and fiscal budgets of those agencies taxed to clean it up is enormous. Latest studies have shown that the direct cost to Iowa law enforcement officials for *cleanup and disposal of the labs during FY-2004 was \$2,923,144*. And the impact that meth abuse has had on the *substance abuse treatment process in Iowa exceeded \$7 million* dollars during that same period.

Methamphetamine has been shown to serve as the primary drug of choice of 15.8% of those in non-criminal drug and mental health treatment in Iowa during FY-2004. That same study clearly indicated that Meth users are "poly" drug users involved in a wide array of drug use and abuse. However, keep in mind, that *methamphetamine use is NOT just an Iowa problem*.

Socio-economic impact study

A study conducted by the Oklahoma Department of Public Safety clearly showed the grand scale of this problem. The study conducted this past year was developed through a survey of known Meth users and manufacturers. It took into consideration the Socio-Economic impact of Meth labs in the state. Consideration was given to mental health, child welfare, treatment, court and correctional costs, investigation and apprehension costs, job retention, property damage and Meth lab clean up.

The average attributed impact of cost on the system *for each Meth lab seized was \$350,000 annually*. In addition, impacts on the family structure, unborn children, educational system and sustaining health care were NOT figured into the equation.

When you multiply this amount by the 1,200+ labs seized by Oklahoma authorities or the 1,400+ seized by Iowa authorities the fiscal impact becomes evident. It should be noted, that since the inception of Iowa's strict pseudoephedrine purchasing law, *we have experienced a 78% reduction in Meth labs* as compared to the same period in 2004.

Impact on our families

In addition, the emotional impact on the citizens of our country is extreme. Family breakdowns and the loss of loved ones who poison themselves through addiction are greater with Methamphetamine than any other illegal drug.

- In Burlington, Iowa a *14-year old girl died from meth overdose* after mixing meth lab residue given to her by her mom's boyfriend with a bottle of pop and than drinking it.
- In Rural Carroll County Iowa an *infant nearly died from a baby bottle filled* with pseudoephedrine and other meth-making chemicals. They were placed there to hide from authorities.
- In Rural Clay County Iowa a *3-month old was removed from her home* where her mother and grandmother and grandmothers' boyfriend cooked and used meth. The meth was cooked in a hidden area next to the baby's room. So toxic was the environment in the room, that all the metal items were corroded due to the acid in the air.
- A Mason City, Iowa *little girl was discovered in a family car seated next to a bubbling meth "generator"*. The vapors of anhydrous ammonia used in the process overwhelmed the interior of the vehicle.
- And then there is *the case of Angela Fatino*. In your packets you will find a copy of the story printed in the Des Moines Register. It discusses how within one year a bright, involved, beautiful 12 year old girl could fall so low; she would end up in a juvenile detention center and eventually take her own life.

I ask that you take a moment to study the photos so you can more clearly gain an understanding of this cold reality called Meth abuse.

Effects on the user

The drug is unique. It has a higher addiction potential than Heroin with symptoms of paranoia similar to those caused by Cocaine. It possesses the hallucinogenic properties of LSD and individuals on Meth gain adrenal strength much like the PCP addicts of the 70's.

It is less expensive and more addictive than Crack Cocaine and easier to get than marijuana. Methamphetamine can be smoked, eaten, injected, snorted or absorbed. Few, if any other, substances can be abused as easily or are as easy to get as Meth. *If you can't buy it, you can make it.* All you need is the right over the counter chemicals and an empty 2-liter pop bottle.

Sheriffs see full impact

As a Sheriff, I have a unique chance to be involved in all aspects of law enforcement. Of the over 3,000 *Sheriff's Offices in our country the overwhelming majority are full-line agencies.* We have community action programs, teach DARE, and enforce motor vehicle and criminal laws while participating in the full gamut of protective services.

But from that point we separate ourselves from the majority of other law enforcement agencies. *98% of the Nations' Sheriffs are elected by the people.* We are directly charged by those citizens who elected us, those same citizens who elected you, to protect and serve the counties and parishes of this nation.

As Sheriffs we are also *active in the Civil and Court aspects* of law enforcement. We serve civil papers and court actions on individuals who have incurred judgments against them. I have seized homes, vehicles and children from families as a direct result of court action brought upon the defendant due to their drug use. Not just through the forfeiture process but directly resulting from the users spending every last cent to maintain their habit. In addition, the Office of Sheriff is charged with the transporting of mental health and substance abuse committals through court order often originating from illicit drug use.

And, *we operate the nations' jails.* No individual is accepted into the prison system without first going through a jail at some time in their process. Due to the large national increase in drug users, we find our cost of in-house health care skyrocketing. In my facility, nearly 60% of the inmates are on some form of prescribed medication. *With the high toxicity level of Meth, we find that users need far more medical treatment.* More and more users must be taken to kidney dialysis or are on anti-psychotic medications so that they can remain stable and capable of fitting into the facility.

A need to band together in support

Ladies and Gentlemen of this Committee, I come before you today to ask your support and assistance. With all the trying times facing this nation, we can ill afford to open the door to more catastrophe and disruption. While our enemies are at our gate, knocking on the door and waiting for us to weaken, we can not allow our nation to destroy itself. This is more than a group of weak individuals using a substance for self pleasure. *It is a major part of our society destroying itself and the country's future.*

I ask that you give *full supporting for efforts currently being considered by Congress that would better fund the fight against Meth and other illicit drugs in America.* To take the "War on Drugs" more seriously now than ever before! *Legislation is needed to secure pseudoephedrine from over-purchase potential and shoplifting cooks.*

We must not turn our backs on those individuals who have dedicated their lives to protecting and serving our citizens. *To cut funding of the JAG/Byrne or HIDTA programs will eliminate drug taskforces in 38 of the 50 states in this country.* I shudder to think of the ramifications of that occurring with inadequate monitoring and enforcement.

Again, I want thank you for the opportunity to come before you and express my concerns. I have the greatest faith in our system of government and know that through your efforts our country will be stronger and more resilient well into the future.

Mr. GILLMOR. Thank you very much. And we go to Joseph Heerens—

Mr. HEERENS. Very good.

Mr. GILLMOR. [continuing] representing the Food Marketing Institute.

STATEMENT OF JOSEPH R. HEERENS

Mr. HEERENS. Thank you, Mr. Chairman, members of the subcommittee. Mr. Chairman, members of the subcommittee, my name is Joseph R. Heerens and I am a Senior Vice President with Marsh Supermarkets, based in Indianapolis. My statement today is on behalf of Marsh, the Food Marketing Institute, and its members nationwide. Thank you for holding this important hearing.

Methamphetamine is a serious problem. Our industry believes that to effectively address it we need a comprehensive strategy and partnership between law enforcement, regulatory agencies, manufacturers, and retailers. Our industry has serious concerns over recent initiatives enacted into law that would impose stringent controls on precursor chemicals at the retail level. I am referring specifically to the Oklahoma model that relegates pseudoephedrine products to Schedule V status.

Under Schedule V, only retail pharmacies or retail stores that have a pharmacy department would be allowed to sell cough and cold products and they would have to be kept behind the pharmacy counter. Schedule V is troublesome because an overwhelming majority of grocery stores in our country do not have a pharmacy department and would be prohibited from selling these products.

For example, my company has 121 stores in the Midwest, but only 47 have a pharmacy. Sixty percent of our stores would be prohibited from selling pseudoephedrine cough and cold products. Accordingly, Schedule V poses significant barriers for consumers, as most neighborhood grocery stores would not be allowed to sell these products.

In terms of pending Federal legislation, the Combat Meth Act of 2005, approved by the Senate last month, our industry firmly believes that this bill in the House version are flawed and in need of significant revisions for the following 10 reasons.

First, these bills failed to provide for a national standard. They allow States to establish different restrictions, making compliance by retailers more difficult.

Second, because these bills do not include strong Federal preemption language. The requirement for a logbook seems superfluous. States and localities could have different restrictions than what might be set forth in a Federal law.

Third, the Combat Meth Act does not exempt liquids and gel caps, even though every State Schedule V law regulating pseudoephedrine products exempts them.

Fourth, the Combat Meth Act would trigger a by prescription only requirement in up to 19 States, meaning consumers would need a prescription from their doctor to purchase pseudoephedrine products, adding significantly to their cost.

Fifth, the Schedule V provisions in these bills will force grocery warehouses to apply for a controlled substances license from the DEA, entailing higher licensing fees and new regulatory burdens, even though these facilities are not a source of supply for the meth cooks.

Sixth, these bills are too narrow in their focus, as they address only 20 percent of the meth production problem. They do nothing to address the lion's share of the problem, which is the estimated 80 percent of meth coming from the superlabs, such as those in Mexico.

Seventh, the Combat Meth Act reduces consumer access to cough and cold products by limiting their sale to pharmacies or pharmacy departments, many of which have space limitations that will reduce the number of products carried.

Eighth, the Combat Meth Act limits purchasers to no more than 7.5 grams in a 30-day period, which may be unfair to large families with allergy sufferers or sick children who need a greater supply.

Ninth, the Combat Meth Act does not adequately address the issue of Internet sales and flea markets, both of which have been problem areas.

And last, the Combat Meth Act allows stores without a pharmacy department to sell pseudoephedrine products under very limited circumstances, but the exemption process is complicated and very few exemptions will likely be granted or granted timely.

As I stated at the beginning of my testimony, the supermarket industry supports a comprehensive solution, as reflected in FMI's recent endorsement of the Methamphetamine Epidemic Elimination Act, introduced by Representatives Mark Souder, James Sensenbrenner, and Howard Coble, along with more than 45 cosponsors. Unlike the narrow focus of the Combat Meth Act, House Bill 3889 seeks to address the problem in a comprehensive manner. And we support it for the following reasons.

We support the elimination of the blister pack exemption and our industry supports reasonable sales restrictions on pseudoephedrine cough and cold products. FMI has recommended a 6-gram limit per transaction. We support the adoption of strong Federal preemption language in order to facilitate retailer compliance. Our industry supports limiting consumer access to pseudoephedrine products by placing them behind a counter that is not accessible to consumers, such as a service counter where cigarettes are kept. FMI members support a Federal exemption for pediatric products, as meth cooks generally do not use them to make meth. We support a ban on Internet sales of precursor chemicals as well as strict limits on mail order sales of pseudoephedrine products. Our industry supports strict quotas and import restrictions on both chemicals of ephedrine and pseudoephedrine. We support a ban on the sale of pseudoephedrine products in infant formula at flea markets unless they have written authorization from the manufacturer or proper business records. Flea markets routinely sell pseudoephedrine products that in many cases have been stolen from retail stores. We support stronger penalties and fines and tough enforcement from the manufacture, possession, or sale of meth. And we support making Federal funds available to the States to help clean up meth labs.

Mr. Chairman, members of the subcommittees, this concludes my statement. On behalf of FMI and the supermarket members across this country, we very much appreciate the opportunity to present our views today on solutions to the meth problem. And I would be glad to take any questions you may have.

[The prepared statement of Joseph R. Heerens follows:]

PREPARED STATEMENT OF JOSEPH R. HEERENS, SENIOR VICE PRESIDENT,
GOVERNMENT AFFAIRS, MARSH SUPERMARKETS, INC.

INTRODUCTION

Chairman Deal and Chairman Gillmor. My name is Joseph R. Heerens, and I am Senior Vice President of Government Affairs for Marsh Supermarkets, Inc., headquartered in Indianapolis, Indiana. My statement today is on behalf of Marsh Supermarkets and the Food Marketing Institute (FMI). FMI is our national trade association, representing food retailers and wholesalers. While my company has no stores in Georgia, we do have thirteen (13) supermarkets in western and southwestern Ohio.

Thank you for holding this important hearing on the impact of methamphetamine on health and the environment, and solutions to address this very serious problem. The supermarket industry fully understands the magnitude of the problem, and we also know that legitimate cough and cold products containing pseudoephedrine (PSE) are used to manufacture meth.

According to law enforcement sources, legitimate PSE products, which are purchased or stolen from retail stores, account for approximately 20 percent of the methamphetamine that is domestically manufactured by so-called "mom and pop" meth cooks, whereas the lion's share of meth in our country (approximately 80 percent) comes from super labs, many of which are located in other countries, such as Mexico. Regrettably, when domestic meth production is curtailed in a state because of enactment of a retail sales restriction law, Mexican drug gangs quickly fill the void with cheaper and more potent "crystal meth". In other words, the problem does not go away; sometimes it gets worse. Thus, it is the supermarket industry's position that to effectively address the methamphetamine problem, we need a comprehensive strategy and partnership between law enforcement, regulatory agencies, over-the-counter (OTC) manufacturers, and the retail community.

Of our 47 stores that have a pharmacy department, general store hours are quite different from the pharmacy department's hours of operation. Most of our supermarkets are open 24-hours. In comparison, however, our pharmacy departments are typically open less than 12-hours on weekdays, and even more limited hours on weekends. Therefore, even if the store is open for business, if the pharmacy department is not open or if the pharmacist is not on duty, sales of PSE cough and cold products would not be permitted and our customers would have to shop elsewhere to meet their medication needs. That causes us great concern.

SCHEDULE V—IMPACT ON CONSUMERS

The bottom line result under a rigid Schedule V approach is a dramatic reduction in consumer access to cough and cold medications depending upon whether their local grocery store has a pharmacy department and the pharmacy department's hours of operation. For consumers living in rural areas or in the inner city, Schedule V can create major hardships if the nearest pharmacy is 15 to 20 miles from their home or if the person is elderly or poor and would have to rely on public transportation in order to get to a pharmacy to purchase a PSE medication.

FMI, along with the National Consumers League (NCL), gauged consumer opinion on sales restrictions of PSE products in a national survey released in April of 2005. What the FMI-NCL survey found is revealing. Forty-four (44%) percent of the 2,900 adult survey respondents felt that Schedule V would create a hardship for them, while 62 percent said they did not believe that restricting sales of PSE products to pharmacies is a reasonable measure for controlling meth production. In contrast, survey respondents were far more receptive to less severe restrictions than Schedule V, such as placing cough, cold and allergy products behind a counter, but not a pharmacy counter, or placing these items in a locked display case on the sales floor. Additionally, more than 80 percent of the survey respondents expressed support for limiting the quantity of such products that individuals can purchase, and 74 percent said it would be reasonable to restrict the age of purchasers.

For all of these reasons, the supermarket industry cannot support a Schedule V classification for cough and cold products containing pseudoephedrine. Schedule V poses significant problems for consumers who have legitimate needs for these medications, including reduced consumer access and hardship because their nearby neighborhood grocery store, which they visit 2.2 times each week, would not be allowed to sell these medicines. In addition, Schedule V may likely mean higher prices, as PSE products move from self-service to behind the pharmacy counter where the pharmacist, who is a highly salaried professional, will be required to ask

for photo identification and have the customer sign a log book. Schedule V just isn't the right solution to this terrible problem.

COMBAT METH ACT OF 2005 IS FLAWED

In terms of pending federal legislation, the Combat Meth Act of 2005 (S. 103) approved by the Senate on September 9, 2005, as part of the FY 2006 Commerce Justice Appropriations bill, our industry firmly believes that this bill, and the House version (H. R. 314), are deficient, flawed, and in need of significant revisions. The following are the deficiencies and shortcomings we see in this legislation:

- S. 103 and H. R. 314 fail to provide for a national standard governing the sale of PSE products. Methamphetamine is a nationwide problem that needs a national solution. Regrettably, this legislation allows states and localities to establish different restrictions on these products, making compliance by retailers more difficult and complicated.
- Because these bills do not include strong federal pre-emption language, the requirement for a log book seems superfluous. That's because states and localities could have different transaction restrictions than what might be set forth in a federal law. Moreover, a log book raises significant privacy issues for many consumers.
- The Combat Meth Act of 2005 does not exempt liquids and gel caps even though every state Schedule V law regulating the sale of PSE products exempts these products.
- Unless the Combat Meth Act of 2005 is amended, the Schedule V provisions will trigger a **"by prescription only"** requirement in as many as 19 states. This would mean consumers would have to get a prescription from their doctor in order to purchase PSE products. As a result, a cough and cold product that normally sells for about \$6 at retail could now cost \$60 or more when you factor in the physician office visit charge.
- Moreover, the Schedule V provisions in S. 103 and H. R. 314 will force grocery warehouses and distribution centers that handle PSE products to apply for a Controlled Substances Registrant license from the Drug Enforcement Administration (DEA). This will entail higher licensing fees and new regulatory burdens for these facilities. Imposing Schedule V requirements and higher regulatory costs on warehouses and distribution centers makes no sense since these facilities are not a source of supply for the meth cooks.
- S. 103 and H. R. 314 are too narrow in their focus. These bills address only 20 percent of the problem in terms of domestic meth production. S. 103 and H. R. 314 do nothing to address the lion's share of the problem, which is the estimated 80 percent of methamphetamine coming from the super labs, such as those located in Mexico.
- The Combat Meth Act of 2005 dramatically reduces consumer access to cough and cold products by limiting their sale to stores that have a pharmacy or a pharmacy department. PSE products would have to be placed behind a pharmacy counter, and, due to space limitations in the pharmacy department, many retailers will not be able to carry and offer for sale the wide variety of PSE medications that their customers need. Moreover, because these products will be behind the pharmacy counter, consumers will no longer have the opportunity to read and compare products and product labels, and to otherwise engage in comparison shopping.
- S. 103, as passed by the Senate, limits purchasers to no more than 7.5 grams within a 30-day period. This arbitrary limit may be unfair to a large family with allergy problems or to a mother with several sick children at home who has a legitimate need for more than 7.5 grams within a 30-day period.
- The Combat Meth Act of 2005 does not adequately address the issue of Internet sales and flea markets. S. 103, as passed by the Senate, allows, but does not require, the Attorney General to promulgate regulations governing the sale of PSE products over the Internet. Furthermore, S. 103 and H. R. 314 have no provisions relating to flea markets which routinely sell PSE products that in many cases have been stolen from retail stores by organized theft gangs. Flea markets should be prohibited from selling PSE products unless these transient vendors have written authorization or appropriate business records from the manufacturer.
- The Combat Meth Act of 2005 allows stores without a pharmacy department to sell PSE products under very limited circumstances. Indeed, the exemption process is complicated and convoluted, involving both state and federal agencies, and very few exemptions will likely be granted and they probably will not be granted in a timely fashion. Individuals living in rural areas that do not

have a pharmacy nearby will obviously be adversely affected by the Combat Meth Act and Schedule V.

- The implementation dates for Schedule V, as specified in S. 103, are unrealistic. For example, single ingredient PSE products would be placed in Schedule V ninety (90) days after enactment, and retailers would be required to maintain a log book. It is unlikely that the Department of Justice (DOJ) would be able to promulgate necessary regulations in 90 days to advise retailers on how to comply with the law.

SOLUTIONS TO THE METH PROBLEM METHAMPHETAMINE EPIDEMIC ELIMINATION ACT

As I stated at the beginning of my testimony, the supermarket industry supports a comprehensive solution to the methamphetamine problem. This is reflected in FMI's recent endorsement of the Methamphetamine Epidemic Elimination Act (H. R. 3889) introduced by Representatives Mark Souder (R-IN), James Sensenbrenner (R-WI) and Howard Coble (R-NC), along with more than 45 co-sponsors. Unlike the narrow focus of the Combat Meth Act, H. R. 3889 seeks to address the methamphetamine problem in a comprehensive manner. This bill is multi-pronged, with provisions that would establish domestic and international controls over precursor chemicals, while providing for more severe penalties for methamphetamine production, possession and trafficking.

In expressing our support for H. R. 3889 and a comprehensive approach for combating methamphetamine availability and abuse here in the United States, FMI members support the following:

- We support the elimination of the so-called "blister pack exemption", and our industry also supports reasonable sales restrictions on PSE cough and cold products. In testimony to the House Judiciary Committee, FMI recommended a 6 gram limit per transaction.
- We support the adoption of strong federal pre-emption language governing the sale of PSE products in order to facilitate retailer compliance. Federal legislation should include language prohibiting local communities from implementing restrictions that are different from sales restrictions that have been established by a state.
- Our industry supports limiting consumer access to PSE products by placing these medications behind a counter that is not accessible to consumers, such as a service counter where cigarettes are kept. Current Georgia state law requires PSE products be kept behind a counter or in a locked display case. FMI and its members do not support a Schedule V designation for PSE products.
- FMI members support a federal exemption for pediatric products so they can remain on store shelves. All indications are that meth cooks do not use pediatrics to make methamphetamine.
- We support a ban on Internet sales of precursor chemicals, as well as strict limits on mail order sales of PSE products.
- Our industry supports strict quotas and import restrictions on bulk chemicals of pseudoephedrine and ephedrine.
- We support a ban on the sale of PSE products and infant formula by flea markets, unless they have written authorization from the manufacturer or other appropriate business records. Flea markets are notorious for being major conduits for stolen merchandise in these two product categories.
- We support stronger penalties and fines, and tough enforcement, including "no bail" for individuals involved in the manufacturing, possession or sale of meth.
- We support making federal funds available to the states to help clean-up the aftermath of hazardous materials found at meth labs.

Chairman Deal, Chairman Gillmor, and Subcommittee Members, this concludes my statement. On behalf of FMI and its supermarket members, we very much appreciate the opportunity to present our views today on solutions to the meth problem.

Mr. GILLMOR. Thank you very much. And let me start with a couple of questions. I will direct the first one to the National Association of Counties and also the Sheriffs' Association. Do you support designating pseudoephedrine as a Schedule V drug under the Controlled Substances Act?

Mr. COLEMAN. Yes, we do.

Mr. KAMATCHUS. Yes, sir.

Mr. GILLMOR. The designation, I think in some cases, could lead to undesired consequences. In 18 States, the designation would mandate that the patients receive a prescription before they could obtain what is typically an over-the-counter medication. And there are other unintended consequences. I guess the question is what policy objection or objectives would you seek to achieve by Schedule V designation and if those objectives could be achieved without a Schedule V designation, would you support that. Yeah, I am the Chairman.

Mr. KAMATCHUS. Okay.

Mr. GILLMOR. The Chairman of both.

Mr. KAMATCHUS. I think right now the reason we support the Schedule V is because of its restriction and obviously it takes it off the street. Pseudoephedrine is the primary additive in making methamphetamine in the local labs. And as law enforcement officers and having seen the result, that is why we support it. It is the most strict as possible. I would mention it, yes that if in fact we could have as strict of a restriction on it along with a verification process that is necessary to ensure that the companies, if you will—the stores, if you will, are in fact doing that, and also a penalty process so that the individual who is selling it from behind the counter has to face the penalty, if you will, for sneaking them out and selling them.

Mr. GILLMOR. Um-hum.

Mr. KAMATCHUS. And then that would be something we would look at. But right now we don't see anything that has exacted that. So that said, with what we see before us, we are in support of the Schedule V.

Mr. GILLMOR. Okay. Thank you, Sheriff. Did you want to jump in—

Mr. COLEMAN. Yes. We—

Mr. GILLMOR. —Commissioner?

Mr. COLEMAN. We support that on the basis of seeing the success that we have had already in Oklahoma and Iowa. And we believe that the policy is in its strength in itself.

Mr. GILLMOR. Okay. Now if we may go to Mr. Heerens, Food Marketing. Do your member companies, even those without pharmacies, have experience in restricting sales of certain products?

Mr. HEERENS. Yes. I can speak on behalf of my company.

Mr. GILLMOR. Um-hum.

Mr. HEERENS. In Indiana this year, we adopted a restrictive meth law that went into effect in July 1 of this year, so it has been in effect for about 3½ months. It is not a Schedule V law. It allows all retailers—it maintains a level playing field for everybody, but allows all retailers to put the product behind, say, the front service desk in the supermarket, and that is not accessible to consumers, or in a locked case on the sales floor. We have done that. We moved—we did carry 213 products with ephedrine and pseudoephedrine. We could not move all of those behind the front service desk. There is just not room. So we cut that down to 40, the top 40, and we stopped carrying 173 products. Since that law went into effect, and the Governor's Office just announced this in Indiana a few weeks ago, we have already seen in the first 3 months a 41 percent reduction in meth lab seizures. So I think you

can achieve substantial results. And that number continues to increase. I am convinced by the end of the year we will be above 50 percent. So you can achieve a significant reduction of meth labs with all the—without all the inconveniences and hardships that it causes to consumers and to retailers. We are in the business to take care of customers' needs. It is very difficult for us to say sorry, we can't carry the product. You can go down the street to a competitor and buy it. That is simply not acceptable. And so we think that the Indiana law is working well and it is not Schedule V. And we would hope that something like that could be crafted at the Federal level.

Mr. GILLMOR. Okay. Thank you. And Mr. Knapp, in your statement you suggested that OTC products should be put behind pharmacy counters. Could you explain why you support restricting sales to behind the pharmacy counters? And do you believe that consumers need the professional training of pharmacists to properly take those medications that are now over-the-counter?

Mr. KNAPP. Mr. Chairman, maybe if I could address the second part of your question first.

Mr. GILLMOR. Sure.

Mr. KNAPP. It is not our point of view that in fact pharmacists or pharmacists technicians need to provide a lot of counseling or education to consumers, particularly around pseudoephedrine. It has been an OTC product widely available in cold and allergy products for almost 30 years at this point in time. And so we believe consumers are quite capable of selecting the product on their own. The reasons we believe that it makes most sense to move all pseudoephedrine based products behind the counter at this point are really twofold. No. 1, and as some of the other witnesses have correctly pointed out, legislation that has restricted access to pseudoephedrine products has made a significant difference in terms of accessibility and in terms of the number of illegal labs. And the second is the availability of other alternatives. We believe we have played a leadership position in introducing Sudafed PE, which is a phenylephedrine based decongestant. It cannot be converted into methamphetamine. And that provides consumers with an alternative in front of the counter. And so we think we can strike the right balance between maintaining access to important medication and still make a major contribution to the fight against methamphetamine.

Mr. GILLMOR. Okay. Thank you. And Mrs. Wagner, representing the chain drug stores, in States that limit the sale of over-the-counter cold products to pharmacies, does the pharmacist routinely provide any clinical diagnosis or apply any professional expertise to dispensing the product or are they simply acting as a gatekeeper to the product?

Ms. WAGNER. I would imagine that occasionally they provide some clinical advice, if the customer asks a question or whatever. But on a routine basis, I would say no. They are just restricting the product. And that is why we on the Senate Bill have advocated they not call it Schedule V for that reason. If the policy is to restrict access to the product, that is one thing. But to call it a controlled substance—you mentioned earlier about the unintended consequences. There are many. By calling it a Schedule V con-

trolled substance, we have now record keeping requirements. We have storage requirements, distribution center requirements, thefts and loss reports. I mean, it is unbelievable the number of requirements on a retail store if it is a controlled substance. So if the purpose is to restrict access, that is one thing. But I don't think it is necessary to call it a Schedule V.

Mr. GILLMOR. Okay. Is there technology currently available that makes it feasible for all drug stores to be interconnected to ensure that individuals are not purchasing over a set monthly limit?

Ms. WAGNER. There is currently not a system like that. However, we would envision that would be the solution that we would be looking for to be effective. If there is going to be a sales limit, and especially if it is over a period of time, in order to have law enforcement there has to be a mechanism for the seller to be able to know how much of the product the customer has bought, not only in their store but in other stores as well. So you know, we have two members who have on their own developed an electronic tracking system within their stores in a couple of different States. That is working quite well. And they get a message back and the point of sale that the person has already exceeded their limit. So we see that as certainly a solution.

Mr. GILLMOR. Okay. Are you sure it is better to restrict sales based on monthly per customer limits or based on the per transaction limit?

Ms. WAGNER. Well, it depends on what, again, what the policy is you are trying to achieve. Certainly a transaction limit would be far easier to implement in a retail store. In fact, many of our members have been doing that voluntarily for years, not necessarily at 3.6 grams, but at 9 grams or 6 grams or something like that. So that is fairly easy to implement. On the other hand, we advocate for a standardized solution. And so many of the States now have a limit of so many grams in so many days. Therefore, we would like to see a consistent approach on a Federal solution.

Mr. GILLMOR. Okay. This is a joint hearing of the Health Subcommittee and the Environment and Hazardous Materials Subcommittee. Most of those questions have been going out of the Health Subcommittee's side. So in fairness, we are going to throw you a couple out of the Environment and Hazardous Materials side. And in that respect, Commissioner Coleman, what do you consider the average amount of money necessary to clean up, for criminal prosecution, and then to fully remediate a meth site? And are those costs increasing or decreasing?

Mr. COLEMAN. We have heard that it takes \$3,000 to \$4,000 to clean up a former meth lab. If you multiply it by the number of meth labs that have been crashed or taken at this—at the rate that we are doing now in Oakland County as well as in Iowa, that can run into quite a few millions of dollars.

Mr. GILLMOR. Okay. Thank you. And Sheriff, one method of cleanup at a meth lab is to have the local or the State government notify DEA, who then in turn takes responsibility for the cleanup of the site. Who has jurisdiction over the environmental determinations and the cleanup? And do you coordinate with DEA concerning these sites to ensure that proper cleanup standards are met?

Mr. KAMATCHUS. In the State of Iowa, we have DEA funded cleanup teams that work for us statewide. They respond—they come in with their kits and their outfits and their—and everything and they secure the lab. It is our understanding that it also runs, because it is a negotiated cleanup cost, around \$2,000 a lab. As far as the standards go, if in fact there are precursor chemicals onsite or indications of precursor chemicals or any apparatus with any residual left in them, we call those teams. Now the big problem for a local standpoint is that it is great to have that disposal paid for by DEA, but we end up putting the manpower out there waiting. Those teams have to come from a long distance. It ties up manpower in a small agency like myself where I only have 19 sworn officers total. We sit on them. And then ultimately that cost comes back to the taxpayer.

I am going to be up front with you on some things. It takes my officers, my taskforce, our full county taskforce off of the real problem, as you have heard mentioned here before. The majority of the meth still comes through that Southwest corridor. No doubt about that. But the amount of man-hours that we put on these little labs takes good investigative staff away from the main problem. It ties them up. So the cost is even more than just dollars and cents. It is what we feel is an unnecessary shift in that cost. I might add my county lost its HIDTA funding. We had been—received notoriety, actually, in the mid-90's about the amount of meth going through our area by some national publications. Well, that secured HIDTA funding for us. But what was happening was our direct taskforce was spending so much time concentrating on these little labs that we began losing touch with that big group that is out there. Along the line I began telling my staff—I said if there is no sign of residual effect, no residue left, then I said we need to determine whether or not we are going to consider that a cleanup project. Now does that meet EPA standards? I don't know. We—probably I shouldn't even be saying that before you, but that is the reality of it all. Maybe EPA needs to look at also what it can do to help us have a better understanding of what we should and what we shouldn't clean up. Because it is expensive and it is a big detriment to the counties out there.

Mr. GILLMOR. Okay. Thank you. That concludes my questions. I would like to ask the members of the panel that may have members who want to submit any questions in writing if you would be willing to respond to those.

Mr. KAMATCHUS. By all means.

Mr. GILLMOR. And I thank you. If you don't mind, before I adjourn, we are going to wait just a couple minutes. We have been informed that Mr. Walden may have a couple questions and is on his way down. Now I don't know if that means he is on his way down from the second floor or from Oregon. If he is coming from the second floor, we will wait a couple minutes. Mr. Walden has arrived—his highly anticipated arrival. Everything in place? I do have one question before we go to the gentleman from Oregon. I represent a rural area, as do a number of members. If legislation—restricting sales only to pharmacies, do you believe that could have an impact on patients' access to cold and allergy medicines? Any thoughts?

Mr. HEERENS. That is one of the issues we discussed in Indiana quite extensively when we adopted our meth law. And the answer to that is yes. We have parts of our State where there just aren't pharmacies. But there is a little grocery store in the county seat. We have got a situation in downtown Indianapolis where people come in for conventions and there is no pharmacies down there except those that are found in a couple of grocery stores. So access is an issue. And I think in some rural parts—Indiana is a farming community for the most part—farming State for the most part. There are some communities where people may have to drive 15 miles if we adopt a Schedule V approach.

Mr. GILLMOR. Um-hum.

Mr. HEERENS. And again, that seems to be overly restrictive considering the success we are having in our State with a non-Schedule V law.

Mr. GILLMOR. Okay. Thank you. The gentleman from Oregon.

Mr. WALDEN. Thank you very much, Mr. Chairman. I appreciate your indulgence and courtesy in allowing me not only to sit in on the hearing to the extent I have been able to today, which isn't much, but also to participate. And I want to thank our witnesses, too. As you know, Mr. Chairman, I represent one of the most rural districts in the Congress, two-thirds of the State of Oregon, 72,000 square miles. But our State has moved ahead with I think the Nation's most aggressive attempt to try and deal with methamphetamine. By July of next year I think they require prescriptions for all pseudoephedrine/ephedrine products. And it was not without controversy and consternation at the State level, but by overwhelming—Republicans and Democrats alike and the Governor all said we have to go down this path. We have to try something. What we are doing now isn't working. And I—what we are going to see is a model. That is one of the best things about States. We are going to find out just how that process works. But I can tell you in my district, I think we have got 40 percent of the labs and 20 percent of the population. Having a county of 70,000, in Umatilla County out in Eastern Oregon, where they did—so far this year busted more meth labs than in Winoma County, which is Portland County, 10 times that size. We have an enormous drug trafficking operation war coming up out of Mexico and California from the superlabs. Congressman Souder, came out and held a hearing for me on Friday in Pennelton. And we went through with law enforcement, with DEA, with others about the challenges we face. Today in the news, there is a story on the financial times that talks about the methamphetamine problem as it relates to oil rigs. And I don't know if you have had a chance to see that, but I would certainly provide a copy for you and submit it for the record. But there are oil platforms now, they are finding, where entire crews have been fired for making methamphetamine. Entire crews. They are actually now having great difficulty finding enough workers to operate some of these crews. Somewhere in here I think it said up to a third in some areas are—they are finding when they test are on methamphetamine. So it leads me to a couple of questions.

First of all, for our—Mr. Knapp, I believe, from Pfizer. Can you talk to me about the alternatives that your company has been try-

ing to develop as a substitute for pseudoephedrine/ephedrine products?

Mr. KNAPP. Yes. Thank you, sir, for that question. I would direct the comments probably to two efforts we have made to do that. We actually commenced a program in 1999 to develop a technological solution for it. It basically would be a chemical solution that would have prevented pseudoephedrine from being extracted and converted into meth, and we called that Lock II. That was the internal name we had for it. Unfortunately, after a number of formulations and significant expenditure by our company—we put in an excess of \$10 million over the 3 to 4 year time period, trying to develop this technology. In consultation with the DEA, what we found was that of all the methods, particularly the red phosphorus methods—

Mr. WALDEN. Um-hum.

Mr. KNAPP. [continuing] and the new solvents, that they could break that technology.

Mr. WALDEN. Um-hum.

Mr. KNAPP. And really, it was disappointing to us. But it was at that point in time we started investigating a second alternative, which was phenylephedrine. And—

Mr. WALDEN. PE?

Mr. KNAPP. PE. Correct. And we made that determination to move to that in March/April of last year. We feel it went pretty expeditiously and in fact launched that product in January of this year, in single ingredient. We are working very hard right now to reformulate our entire product line. We believe in excess of 80 percent of our products that used to contain pseudoephedrine will be reformulated to PE by mid-year next year, representing well over 75 percent of our sales. So we feel we are making great progress. And I think from an industry perspective, we have certainly brought the other players along with us. A number of players have followed very quickly. And we feel that this is the right way to go.

Mr. WALDEN. And I appreciate your investment and your willingness to pursue an alternative. Because my limited understanding of this is that without ephedrine or pseudoephedrine, you can't make methamphetamine. That is the one precursor—there are other recipes. You can use other ingredients. But you have to have that one. Now I want to thank our representatives from the National Association of Counties. Commissioner Coleman, thank you for being here. And I want to thank NACo for taking the lead on this issue. The survey that you all did was tremendously important. And Bill Hansel is a constituent of mine that is now President of NACo and actually was at our hearing on Friday. So thanks for the work that you are doing.

Sheriff, I have a question for you. My sheriffs tell me that 80 to 85 percent of the property crime we are seeing, 100 percent of every case of parental rights termination in my State of Oregon are related to methamphetamine. Both of those. Are you seeing that among your sheriffs nationwide?

Mr. KAMATCHUS. We are finding out that over 80 percent of the property crimes—actually, over 80 percent of the individuals in our jails in Iowa have some sort of fringe, if nothing else, involved with

methamphetamine, whether it is domestic violence, whether it is theft—

Mr. WALDEN. Right.

Mr. KAMATCHUS. [continuing] or of course, whether it is the drug use itself. As far as domestic violence and a lot of the involvement of family disputes, the things that you mentioned, I am not sure exactly what the numbers of that, but I have heard over 90 percent also in that area.

Mr. WALDEN. And I think—I did seven summits around my district in February and March. We had panels, much like what we have had here today. And every time I held one of those and went to the next one I didn't think it could get any worse or I could hear anything more troubling. And then you would hear something else. I mean, we had high school kids testify at one where they referred—they said the girls at their school referred to methamphetamine as the Jenny Crank diet and would take it for weight loss. Unfortunately, part of the weight they lose is their brain because we also had the CAT scans that show the erosion/corrosion of the brain that never comes back. And that is what I think has led Oregon to take the initiative we have taken, as inconvenient as it could well be and as costly, I think, for some of the supermarket or, you know, various convenience stores.

The final question I have—I realize I have about exhausted my time and hospitality here. But I appreciate both, Mr. Chairman. The other question I have, my concern is coming out of this hearing Friday we had out in Oregon, that if we take the pseudoephedrine/ephedrine off the market, that two things are likely to occur—well, three things. We will see a drop in labs. And indeed, just putting it behind the counters we are seeing a 56 percent drop in labs in Oregon since the legislature took that—or the Board of Pharmacy took that step. This is before it goes prescription.

The second event is a concern that the purchasing of these same products will go to the Internet and you just but it off the Internet, which I have legislation to try and deal with. The third issue is that it will incent a higher quality crystal meth from superlabs. And I wonder from our panels' perspective if that is something you are concerned about or have seen or if you have any information on that.

Mr. KAMATCHUS. You know, if I could just address that real briefly. In the 90's before all the small labs came up, we were dealing then with the Southwest corridor labs, the Mexican meth, if you will. And we had a pretty good grip on it. I know that four of the drug cartels in Mexico that we knew of that were actually pipelining it into Iowa and then into the Midwest, two of those four labs we hit extremely hard and knocked down. And our seizures went down with that. And frankly, it is because of that that we began seeing that these small labs popped up where the addicts were needing to find something for their addiction. And they went online and they found out how to make the Nazi method crank and the—and what we see today has grown out of it. I made a comment earlier that one of the biggest problems with these small labs is that they take an enormous amount of investigative time and manpower to sit on.

Mr. WALDEN. Yeah.

Mr. KAMATCHUS. So therefore——

Mr. WALDEN. Yeah.

Mr. KAMATCHUS. [continuing] our efforts just aren't adequate to concentrate on those superlabs. So what we are hoping here and what we are seeing in Iowa, as a matter of fact, since we have seen our big 78 percent reduction is now we are starting to work together and we are concentrating on the big labs more. And hopefully that will have an effect, too, in the long run. Again, like we saw before. But now they won't have anything to fall back on if we can attack those big labs, those big drug movers.

Mr. WALDEN. Anyone else have a comment? Finally, the—I know I said finally the last time, but keep doing that, you know, they think you are done and you are really never done. Talk to me about the importance of Byrne Grants, COP Grants, HIDTA. I hear from my law enforcement people those are essential in their ability. And the other element is this notion that they have got to sit on these labs until a cleanup agent can get there to deal with them. And I wonder if anybody has any success at alternatives to that.

Mr. COLEMAN. Well Congressman, they fund our prime taskforce. And without this funding, it becomes an undue burden on the taxpayers because we have to clean up the work. We have to stop the growth of these labs. And we have to make these arrests. In making these arrests, it causes overcrowding of our jails. It causes an early release of prisoners of less offenses. At the same time, it is putting an undue burden on our sheriff departments and our manpower, which causes us—in the State of Michigan, where we do have financial problems, it increases the burden that we have in trying to face and to balance our budgets. So without this money, where do we go? There is a limit to what we can do. And we need the Federal help necessary to combat this problem.

Mr. WALDEN. All right.

Mr. KAMATCHUS. If I might just address that also, Congressman. In our taskforce in Iowa, we get about \$200,000 to fund it. And without that, the taskforce falls. It is done with. As a matter of fact, there has been studies that have shown as many as 38 States in this country would have a definite effect on—a devastating effect, because they are overwhelming funded by that Byrne/JAG money. We see a push toward high intensity drug trafficking areas in that process. And it is a good process, by the way. But in Rural America, the small agencies out there in particular, the majority of their drug funding—and this is where these small labs are and exist, comes from the Byrne/JAG system. And to see the cuts is going to have a devastating effect on us. Most States are like Iowa. We have a ceiling that is preset—the amount of taxes that we can go after. We are at the top of that. So we began saying where are we going to cut services in order to pay for the drug fighting.

Mr. WALDEN. Yeah.

Mr. KAMATCHUS. So it is devastating, sir.

Mr. WALDEN. Okay. All right. Finally, what is the most important thing we can do here to help in this process? Forget—we will assume more money is on the—I mean, you have already—that is always an answer. But structural legislatively, to attack this problem that is eating up our communities—we won't even talk about treatment, which is a whole other issue and I am very supportive

of, but from your perspectives, what is the most important step Congress can take to try and get this methamphetamine crisis back to a more—we won't get rid of it. It is like any other bad thing out there. But how do we get it back toward the bottle and the cork closer to putting it on top?

Mr. KNAPP. I think, sir, if I could at least address Pfizer's point of view on that, I—the one thing I think is most important is that Congress pass legislation that puts all types of pseudoephedrine containing products behind a secure counter, whether that be a pharmacy counter or a secure counter somewhere else in other stores to address the rural issue. But we fundamentally believe that is probably the most important thing that could occur here.

Ms. WAGNER. And if I may, I am with the National Association—

Mr. WALDEN. Right.

Ms. WAGNER. [continuing] of Chain Drug Stores.

Mr. WALDEN. Right.

Ms. WAGNER. We agree that we think the one thing that probably should be done is to pass a Federal comprehensive standardized approach to solving this problem. We all agree it may only attack 20 percent of the methamphetamine problem in our country. But nevertheless, if we can eliminate that part of it and devote resources then to the bigger problem—

Mr. WALDEN. Right.

Ms. WAGNER. So we feel passing a Federal bill that would give a standardized approach on it would be the one thing you could do.

Mr. WALDEN. Okay. Sheriff?

Mr. KAMATCHUS. I have actually have been coming here now for about 10, 12 years and dealing with methamphetamine—to Washington. And over the period of time in my 18-plus years as a sheriff, I have heard fellow politicians, I will say, because I am elected also, statesmen. Thank you. Coin the phrase “War on Drugs”. I know many people who beat the drum in the 90's saying they were going to fight the war on drugs. Then we need to fight it like a war. And we need to do something. And we need to take action and we don't need to beat the drum forever. We need to take action and move forward. So I think taking a direction, working with the professionals that you are—that is the nice thing about having this type of Committee, and then moving forward in that direction and not looking back. I think that is the best thing we could ask you to do.

Mr. WALDEN. All right. Sir?

Mr. HEERENS. I would agree with the comments that have been made. I think obviously getting pseudoephedrine behind the counter is very important. We have seen significant reductions in our State since we did that just 3 months ago. I also think the biggest thing you could do is somehow find a way to shut down the superlabs and the 80 percent—

Mr. WALDEN. Yeah.

Mr. HEERENS. [continuing] that is coming in from out of the country.

Mr. WALDEN. Great. Commissioner?

Mr. COLEMAN. Yes. What we need is a comprehensive approach to the problem. We need it at the floor level, not necessarily at the

ceiling level, to address the issues of the precursors, the child neglect, the abuse, the cleanup, the environmental dangers. Once it is—for example, once a location is identified as a meth manufacturing home, it is not just that house that is contaminated. It is the neighborhood that is contaminated and all that live in that area. So it is not just a money approach but we need a comprehensive approach when dealing with this major problem.

Mr. WALDEN. All right. I want to thank all of you. And again, Mr. Chairman, thank you for your very generous clock and the staff for your help on this hearing. Thank you, sir.

Mr. GILLMOR. Okay. I want to once again express my appreciation to our witnesses and we stand adjourned.

[Whereupon, at 2:15 p.m., the subcommittee was adjourned.]

